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HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

January 24, 2000

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 11/22; 12/13 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *HIV Health Services*	**5:00 PM**
	• *Mayor's Liaison - Bill Barnes*	**5:05 PM**
	• *Steering Committee*	**5:10 PM**
	Council Support Contract	
	• *Implementation & Evaluation Committee*	**5:15 PM**
	Reggie Task Force—Update	
	Quality of Care Task Force—Update	
	Six-month Workplan	
	• *PWA Caucus*	**5:30 PM**
	Stipends & Reimbursements; Policies & Procedures—**VOTE**	
	Mission Neighborhood Community Forum—Update	
	• *Membership Committee*	**5:40 PM**
	New Member Nominations—**VOTE**	
	• *Housing Committee*	**5:50 PM**
Break		**6:00 PM**
	• *Grantee Assessment Task Force*—Presentation, **Barbara Rosa**	**6:15 PM**
	• *Grantee Assessment*—Presentation, **SFDPH, HIV Health Services**	**6:50 PM**
	• *Grantee Assessment*—Presentation, **SF Contractors Association**	**7:10 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Tues	1/18	REGGIE Task Force	25 Van Ness, Room 330B	3:00 – 5:00 PM
Tues	2/1	Membership Committee	25 Van Ness, Room 330A	5:30 – 7:30 PM
Wed	2/2	Housing Committee	25 Van Ness, Room 330B	3:00 – 5:00 PM
Wed	2/2	PWA Caucus	25 Van Ness, Room 330B	5:30 – 7:30 PM
Mon	2/7	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Tues	2/8	Quality of Care Task Force	25 Van Ness, Room 330A	3:30 – 5:00 PM
Wed	2/9	Quality of Care Task Force	25 Van Ness, Room 330A	9:30 – 11:00 AM
Mon	2/14	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
		REGGIE Task Force	TBD	TBD
Mon	2/28	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

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HIV HEALTH SERVICES PLANNING COUNCIL

Minutes, January 24, 2000

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I. Call to Order
4:30 PM

II. Roll Call
Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Agenda accepted by consensus.

IV. Review and Approval of Minutes
11/22/99 Council Meeting Minutes and 12/13/99 Council Meeting Minutes – Minor corrections of names were noted. Motion to approve the minutes agreed upon by consensus.

V. General Announcements

- *Saddiq Jihad* spoke briefly about his experiences at the recent national meeting sponsored by HRSA, called the All Titles Meeting. He and *Ray Combs* attended from San Francisco's Planning Council. *SJ* said they would give a full report next month.

- *Laura Thomas* handed out some materials, including newsletters from HRSA. There is also a press release from the SF Dept. of Public Health about a national study of unmet needs for supportive services to people with HIV. Also available is a flyer about a conference on Hepatitis C. Two other meetings are upcoming: a San Francisco community forum to report back on material presented at the 7th National Conference on Retroviruses and Opportunistic Infections (Thurs, Feb. 17, 6:00 to 8:30 PM at the Palace Hotel) and a community forum concerning Transgender Healthcare and HIV (Thurs, March 2, 2:00 to 4:00 PM at 25 Van Ness).

- *Jeff Byers* reported that the state has released the Title II awards for the coming year beginning April 1. There was a slight increase in the amount for San Francisco, a slight increase for San Mateo and a decrease for Marin County. Overall, the EMA did pretty well.

- *Laura Guzman* talked about a new federal law, the Ticket to Work and Work Incentives Improvement Act. She will be keeping everyone informed about how this important set of changes in Social Security regulations affect people with HIV/AIDS.

VI. Public Comment

- *SJ* asked that public comments be limited to no more than three minutes each.
- Michael Petrelis made comments about the latest Quarterly AIDS Surveillance Report for San Francisco. He covered some of the AIDS case totals for 1999, and characterized the declining numbers as "good news."
- Dave Pascarelli with ACTUP San Francisco talked about AIDS being over and argued against HIV+ people taking medications. He said there is no epidemic here; he asserted that HIV doesn't cause AIDS, the HIV antibody test is unreliable and AIDS drugs are poison.
- Bob Teague with the AIDS Education and Training Center (AETC) introduced himself as someone who has been nominated for a position on the Council. He also passed out further information about the Transgender Healthcare training which Laura Thomas had previously mentioned.
- Carmen Madriz, a clinical social worker at San Francisco General Hospital, introduced herself as another nominee to serve on the Planning Council.
- Fernando Gomez-Benitez also is nominated to a seat on the Council. He works at Mission Housing Development Corporation and Mission SRO collaborative.

VII. Reports

VIII. Mayor's Liaison

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Bill Barnes talked about some current issues. Dr. John Kaiser, who has an HIV practice serving about 500 persons, is in a payment/reimbursement dispute with Medicare. This will be in the news. The Mayor and Congresswoman Pelosi are both involved in trying to resolve the problem and prevent it from affecting the clients at Dr. Kaiser's clinic. On another subject, Mayor Brown is very disappointed about the reduction in CARE Act funding. He is using his contacts to try to find out why this happened. Bill said his office will be in touch with the Dept. of Public Health and the HIV Health Services Planning Council about how to mitigate the impact of these cuts. The number of living AIDS cases continues to increase in San Francisco. The complexity and costs associated with care continue to be greater. AIDS is far from over. He wants to work over the next year to ensure that people living with HIV get the services they deserve. Finally, he referred to a Carol Migden-sponsored law passed by the State Legislature that also makes some changes to state rules and charges regarding MediCal when a disabled person with HIV goes back to work.

IX. Steering Committee

Eric Whitney, Council Co-Chair, gave a report on the issue of Council support. The current set-up is set to expire at the end of February. Thus, the Council is exploring a new option, putting the Council support functions into a service contract. This change would mean that clerical support people would no longer be employees of the Council. The Co-Chairs would not have to be employers. Discussions are underway with the Positive Resource Center to possibly start a project whereby their clients, who are HIV-positive, could act as clerical support staff for the Council. The Council's Consumer Rights Advocacy Project might also be included in the same contract.

X. Implementation and Evaluation Committee

Stephan Oxendine, talked first about the Quality of Care Assessment. The centerpiece of the effort so far is the client satisfaction survey, which the committee felt should be standardized and universally applied as a survey methodology by all contracting agencies. The Committee will pursue a work plan of establishing a Task Force, composed of consumers, agency representatives and Council members. It is hoped that the process will have a stable group of participants, who can design and plan the implementation of a new client satisfaction tool. Orientation meetings are set to kick off this process in early February. The I & E Committee has also decided that it needs to develop six-month work plans for itself, with some attention paid to writing down the mechanics of the Council's work history and the natural cycles of activity, those that come up every year, for example. The I & E Committee will be working on a number of things over the next six months, including some issues left pending as a result of the recent Prioritization that must be revisited; programs currently receiving funds that must be evaluated; an attempt needs to be made to examine what other EMAs are doing with regard to program evaluation; and a guidance needs to be written about such important activities as the Prioritization Process and the two yearly rounds of "un-funds."

The Reggie Task Force

Gene Gowdey reported that there have been two meetings to date. They were excellent, well-attended meetings (about 30 people at each one). They have collected testimony and public input from both consumers of services and agency personnel. Consensus has been reached on five primary areas of concern. Language will be crafted into a motion for consideration at the next Council meeting.

Reports (cont.): HIV Health Services of DPH

Michelle Long Dixon started her presentation by bringing news of our Title I grant award for FY2000--$35,246,477 or 2.68% decrease from last year. This is made up of a formula amount and a supplemental award, with the latter having a sub-category of funds from the Minority AIDS Initiative (formerly Congressional Black Caucus). This sub-category of funds needs to be spent on new or expanded programs for people of color, and the Council must submit a concrete plan for such new/expanded programs before the funds will be released. The challenge is to utilize those dollars for programs that increase access to healthcare services for underserved populations.

Next, she touched on the necessity for the Council to update and revise its Reductions Protocol, which had previously been calculated to deal with a reduction of approximately 2%. Deeper cuts are now necessary. A plan for accomplishing these cuts must be formulated rather quickly because the staff at HHS wants to begin developing contracts for the coming fiscal year, starting March 1. Some services may have to be cutback or closed down. This requires taking the time for proper planning of closures or notice of program reductions. Michelle called upon the

Council to set up a special meeting for February 7, with the objective of approving a protocol for how to implement deeper cuts. A question came from *Sam Kaplan* about any feedback given so far concerning the grant application and any reasons offered for the decreased funding. Michelle said only that HRSA would be providing documentation related to perceived strengths and weaknesses in the grant application. There may be indicators of things that can be done differently next year, as far as program planning and presentation are concerned. She added, however, that she views the reduction as not unexpected news. This lower level of funding requires that the Council does some further work and continues its planning for reductions. She feels that solutions can be found and the losses can be mitigated. A question from *Gene London* centered on the possibility of using funds from the San Francisco General Fund to offset some of the reductions in the Title I grant award under the CARE Act. Michelle responded that this is not looking like a realistic scenario, but that such options will be explored in meetings between the Mayor's Office and the Dept. of Public Health.

XI. PWA Caucus

EW presented the caucus report. The Council voted, back in September 1999 to make stipends available to any Council member who is HIV-positive and eligible to receive services. The PWA Caucus was charged with developing policies and procedures for how the Council can provide such stipends. He distributed a copy of proposed policies and procedures, as well as a form for use in order to receive a $50 stipend. The PWA Caucus approved these policy and procedural changes. Now, the full Council must vote on this revision. The PWA Caucus also reviewed the issue of childcare reimbursements for any Council member who needs that service in order to attend meetings. Forms were prepared by Eric and approved by the fiscal agent, which will enable stipends and reimbursements to be paid. The forms require a Council Co-Chair's signature. *John Conley* expressed reservations about this policy and how CARE funds could be used as childcare reimbursements in the case of any member of the Council who was not eligible to receive CARE-related services. *EW* responded that no member who was paid by an employer to attend meetings could apply for the reimbursement. However, it was felt that the Co-Chairs should not have to ask for individual tax returns in order to establish financial eligibility. The need for this reimbursement would have to be accepted without complicated background checks. At this point a member of the public, Michael Petrelis, inquired about a past issue related to theft of equipment and asked who the new "Ombudsman" was. *SJ* responded to part of the question by saying that the Mayor's Office is handling the matter of the equipment. And, the office of Consumer Rights Advocacy has taken the place of the "ombudsman." The issue of changing policy and procedure in order to accommodate stipends and childcare reimbursements was then put to a vote. The Council voted 23-0 (with 0 abstentions) to accept this revision.

The PWA Caucus also has scheduled another in their series of community forums. This one will be February 25th at 7 PM, Mission Presbyterian Church (3261 23rd St., one block off Mission St.) Everyone is invited to attend this Mission Community Forum.

XII. Membership Committee

The Council now has a membership of 30 people and 10 open seats. *Laura Guzman* estimated that about one-eighth of the members were not meeting the minimum attendance requirements during the past quarter. She thought that those members would be receiving a letter about this. She also listed the people whose applications were reviewed by the Membership Committee. These are the people who, after being interviewed, were thought to be serious about contributing to the work of the Council and should therefore be forwarded to the Mayor's Office for consideration as new appointees. Thus, nine nominees will be sent to the Mayor, if approved by a Council vote in order to fill some of the 10 vacancies. *JC* asked if any of the people were from San Mateo County, and the answer was no. Donald Bliss is in the category of current Council members whose re-nomination has been approved by vote of the Council, but the Mayor has taken no action to date on his possible re-appointment. His name will again be on the list of people sent to the Mayor. There was some limited discussion about the status of Council member Mary Jane Wood, as well as the representation of San Mateo County. These issues were not fully resolved, but Mary Jane Wood's name will also be added to the list sent to the Mayor.

A roll call vote on the list of nominees resulted in a unanimous approval by vote of 23-0 (no abstentions). *Laura*

closed by calling for members to look for HIV-positive people, who would be able to be active participants in order to maintain the membership balance that is called for in the Council's bylaws.

XIII. Housing Committee

Ali Riker gave a short report. She called attention to an attachment of the Housing Committee December Report (contained in the packet of materials). This highlights the program funded out of last year's rollover request: Lutheran Social Services' eviction prevention effort. She said the committee was very impressed with how they have responded to client needs in several concrete areas related to finding or maintaining a place to live. She is hoping to have staff from LSS give a presentation directly to the Council at next month's meeting. In addition, there is a HOPWA orientation coming up. New members of this Council may want to attend such an orientation session coordinated by the Redevelopment Agency.

XIII. Next General Council Meeting Scheduled for February 7th

Members voiced their approval for a special Council meeting on Feb. 7, 2000. It can be held in the same room, #201 of City Hall, which is available from 3:30 to 5 PM. It will have to overlap with a previously scheduled meeting of the Reggie Task Force. The regular monthly meeting of the I & E Committee will take place after the Council meeting at around 5:30 PM, back at 25 Van Ness in its regularly scheduled room.

XIV. Grantee Assessment Task Force/Presentation by Barbara Rosa

Allen Meyer introduced this presentation by pointing out that the Ryan White CARE Act mandates this type of assessment. One of the responsibilities of the Planning Council is to assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area and assess the effectiveness of the services offered in meeting the identified needs. The Council had decided that such an assessment would be done with the help of outside consultants. The Council prepared a Request for Proposals, and the Bernal Group was selected. Barbara Rosa is the principal of this consultant firm; Allen Meyer introduced her.

She made available some printed copies of the transparencies being used to illustrate her presentation as well as copies of her overall report. The information now being presented is contained in the Executive Summary. She started by saying that her firm had conducted a systems assessment with three areas of analysis: 1) the role of the Planning Council; 2) the role of service contractors; and 3) the role of HIV Health Services/DPH. The assessment was not designed to include a scientific methodology, but rather was a methodology for collecting information based on perceptions and then attempting to verify the validity of those perceptions. This study represents a baseline analysis. The process began with preparation of a questionnaire, which covered the following five areas: 1) RFPs (requests for proposals); 2) contract development & certification; 3) invoicing & reimbursement; 4) program monitoring; and 5) communication among the parties. She said questionnaires had been sent to 68 contractors or MOU agencies, with 31 of these responding. The process also included a separate questionnaire for members of the Planning Council. This included four areas of interest: 1) basic demographic information; 2) participation in the work of the council; 3) understanding the role of the council; and 4) perceptions of the relationship with HIV Health Services/DPH. Then the process involved on-site interviews with 12 contractors as well as meetings with senior staff at DPH (both program staff and fiscal/accounting staff). Finally, the process involved discussions with people in approximately 10 other EMAs and their Planning Councils or their grantee staff.

Barbara Rosa went through the five areas covered by the assessment and presented a series of recommendations. These are detailed in the report and in written copies of the presentation slides. All together she presented some 44 recommendations.

Among the overall conclusions contained in her report, she emphasized a few. By far, the most troublesome of the five areas examined is the contract development and certification area. Then, covering other topics of interest, she said that no difference in standards was found as they were applied to contracting agencies vs. MOU agencies. However, she said that considerable variation was found in how DPH policies and procedures were applied by different members

of staff. At the time of the Planning Council questionnaire, there were 36 members and, of these, about 20 returned the survey. The issues that emerged from this part of the assessment were those involving communications and trust. As regards the functioning of other EMAs and their councils, she found wide variation in grant amounts, numbers of contractors and Planning Council size. In addition, she pointed out that HRSA has no nationwide performance standards to be used in administering the grants.

Questions for Barbara began by attempting to clarify some of the points she had raised. *Mike Shriver* asked about the perception that a conflict of interest had existed for a member of an RFP review panel. Barbara Rosa said this incident had been investigated and that it appeared that the complaint was valid. *Veronika Cauley* asked about the low response rate on the part of contracting agencies, and wondered if there was any sort of mandated participation. The response was that no requirements were stated to the contractors. *Bill Barnes* asked if the report attempts to correlate perceptions of contractors with regard to the time it took to certify their contracts with a follow-up examination of exactly how long it did take. Barbara said that yes, this data was contained in the full report. *Bill* also asked if the report analyzed to what extent funding was actually reaching the areas of greatest need. *Allen Meyer* interjected that it was the Planning Council's Needs Assessment that analyzed the areas of greatest need. The Council's priorities were based on that Needs Assessment. Therefore, this subsequent report does not significantly address that particular issue. *Bill* was not satisfied with this response because the question posed for the grantee assessment process continued to highlight whether the AIDS Office was working efficiently and was rapidly allocating funds to the areas of greatest need. Since that was the question to be answered here, why was that not a focus of discussion?

Laura Guzman characterized the list of recommendations as a "laundry list." She called for a better method of organizing the material, as a means of addressing the issues in a more systematic and concrete way. The response was to confirm this view and to say that was what had been requested. Barbara Rosa felt that now it would need to be negotiated by all the players involved how to identify the priority issues. *Laura* still wanted a more manageable summary of the issues in preparation for addressing necessary changes. *Stephan Oxendine* asked about contractor's perceptions and how some of these perceptions got translated into recommendations in this report. The response was that there are indeed some failures in efficiency on the part of AIDS Office staff when it comes to asking repeatedly for items that are supposed to be kept in "institutional files." She felt that perception was sufficient basis for saying that this was a reality in this case. *Stephan's* next issue concerned the process of conducting monitoring reports. Barbara's response was that the feedback coming from monitoring reports does not reach contractors in a timely fashion. Some contractors reported never receiving copies of their monitoring reports. This falls under accountability and it is recommended that staff be held accountable for carrying out procedures in a timely manner.

Mike Shriver asked if it was possible to identify which issues were the result of perception and which had been substantiated in fact, because he's aware that contractors are an invested party in this discussion. He questioned if these perceptions can become the basis of changing policies and procedures. Barbara said she would have to think about her response, but also asked that members read the entire report to see if this is still a problem. Her oral presentation hit the highlights, but the full report contains much more detail. In most cases of contractors reporting their problems, they were able to identify the staff people by name. In other words, the complaints represent perceptions with detailed support. Contractors are usually able to back up their complaints with specifics. But, she was uncomfortable including names. *Siddiq Jihad* said that he was concerned about having three final reports and about what continues to be brought up by other members, the dominance of perception over facts. He said he would have preferred that the consultants had attended a committee meeting where these debates could have taken place. Barbara responded that the contract called for communications with the Grantee Assessment Task Force, not other committees.

Next, Jim Illig made a brief presentation on behalf of the HIV Contractors Association. He started by stating that the response rate to this survey was 56%, a pretty good response from contractors. He returned to the defined question of the assessment: "Is the HIV Health Services efficiently and rapidly allocating funds to the areas of greatest need?" He was concerned that this question was not answered in sufficient depth. The contractors association will be examining each of the report's five sections and developing their own set of recommendations.

Michelle Long Dixon gave a response on behalf of HIV Health Services/DPH (the grantee and subject of this

assessment). She first clarified that she was responding to the first version of the final report. A copy of her written response is attached to the report, which was distributed. She wanted everyone to note that HHS/DPH is working with the Council and the Contractors in order to make a range of improvements, specifically in the areas of communication, performance standards, accountability and technical assistance. She looked particularly at the issues surrounding technical assistance and noted that the Planning Council had responded to the needs and allocated additional funds. She also emphasized that contracts are legally binding documents and not spelling exercises. At this point she took the time to talk about the dedication of her staff and to support the job they do. She said that some of the fiscal recommendations in the grantee assessment would cause increased work, not only for DPH staff but also for staff in contracting agencies. The RFP process in 1998 had been a complicated one, but she also wanted to acknowledge that a lot of hard work went into making it a fair process. Everyone recognized that this was the first of this type of assessment, so she wanted to offer some comments about the process for the benefit of future planning. She wanted to have a specific time frame on which to base the examination, feeling that this time a lot of old issues are clouding the focus. She clearly wants the opportunity to review such documents in the draft stage and have a period of deliberation about changes to the report. There are no standards from the funder about this evaluation nor were there any agreed upon standards as this process got underway. In the future she recommended agreement on a set standards in advance, as well as agreement on the questions to be answered. She asked what was the impetus for doing an assessment such as this. Why now? Is this a process that could have been done in a simpler and more direct way? She questioned the cost effectiveness of this process.

LG expressed her concern about the comments from various council members following Michelle's presentation. She characterized some of the commentary as being in the nature of personal attacks. She said that every member bore some responsibility for how this assessment process had proceeded. *SO* disagreed, saying that some members were engaged in trying to make this a better document, one that would be more helpful to the overall objectives that have been undertaken by the Council. He felt that other members had engaged in trying to thwart that effort to make this a better document. He wanted to work out in advance of this meeting what was perception and what was fact. He wanted the AIDS Office, the contractors and the consultants to sit down in an effort to make this a more objective report. He said such a mechanism would have gotten closer to the type of assessment that would provide the information members wanted to know about. *Gregory Edwards* talked about his view of how this situation had developed as part of a cumulative effect. He commended the HIV Health Services for their work and their competence. *Allen Meyer* responded by acknowledging that this has been a 14-month process in which a lot of things have happened. He felt that some members were actually voicing opinions based on isolated incidents and not the whole picture. He felt the need to review the full documents and then look at ways of improving this process for the future. He felt disheartened that members were focusing on problems in the process rather than deciding to help create a climate in which people could work toward the goal of a making the city's bureaucracy function better. *GE* said the content could not be separated from the quality of the product in this assessment report. *SJ* said that the process has led to a better relationship between the Planning Council and the AIDS Office. He also supported the sense of emotion that members are bringing to the table. He said we should be able to come out of this in better shape, if we don't get stuck in animosity. *SO* said his problem was not with the 14-month process, but rather with the final part concerned with putting out a document that accurately reflects the process and that has a positive impact outside of San Francisco. It is a benchmark document and it should be based on facts. Bill Barnes expressed the view that the recommendations from this process should have been used to make some needed changes in the way the system operates. At this point he doesn't feel that he can go to the Mayor with suggestions for change, such as charter amendments or adjustments in the Controller's office. He would like that still to happen and he's not abdicating the role he had said he would play with the Mayor.

XV. New Business

VC again wanted to spread the word about meetings pertaining to the issues of Transgender healthcare. A community meeting is scheduled for the following evening.

XVI. Meeting Adjourned

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

January 24, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Alliena Baker	*AB*	P	Y	Y							
2. Hazel Betsey	*HB*	P	Y	Y							
3. Donald Bliss	*DB*										
4. Jeff Byers	*JB*	P	Y	Y							
5. Bart Casimir	*BC*										
6. Veronika Cauley	*VC*	P									
7. Raymond Combs	*RC*										
8. John Conley	*JC*	P	Y	Y							
9. Luis De La Torre	*LDT*										
10. Mark Dunlop	*MD*										
11. Gregory Edwards	*GE*	P	Y	Y							
12. Catherine Geanuracos	*CG*	P	Y	Y							
13. Gene Gowdey	*GG*	P	Y	Y							
14. Laura Carcagno Guzmán	*LCG*	P	Y	Y							
15. Siddiq Jihad	*SJ*	P	Y	Y							
16. Sam Kaplan	*SK*	P	Y	Y							
17. Gene London	*GL*	P	Y	Y							
18. Allen Meyer	*AM*	P	Y	Y							
19. Jim Mitulski	*JM*	P	Y	Y							
20. Norm Nickens	*NN*	P	Y	Y							
21. Jorge Ortíz	*JO*										
22. Stephan Oxendine	*SO*	P	Y	Y							
23. Ken Pearce	*KP*	P	Y	Y							
24. Alissa Riker	*AR*	P	Y	Y							
25. Nilda Rodriguez	*NR*	P	Y	Y							
26. Susan Shea	*SS*										
27. Mike Shriver	*MS*	P	Y	Y							
28. Al Terrazas	*AT*	P	Y	Y							
29. Kelly Wallace	*KW*	P	Y	Y							
30. Eric Whitney	*EW*	P	Y	Y							
31. Mary Jane Wood	*MJW*	P	Y	Y							

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

February 7, 2000

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VI.	**Reports**	

- *SFDPH, HIV Health Services*
  Review of Reduced Funding scenarios — **4:00 PM**

- *Implementation & Evaluation Committee*
  Discussion & formulation of Reduced Funding Protocol
  Approval of new Reduced Funding Protocol—**VOTE** — **4:15 PM**

VII.	**New Business**	
VIII.	**Adjourn**	**4:55 PM**
		5:00 PM

Upcoming meetings:

Day	Date	Type	Location	Time
Mon	2/7	Reggie Task Force	25 Van Ness, Room 330B	3:00 – 5:00 PM
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HIV Health Services Planning Council, 1540 Market Street #301, San Francisco, CA 94102
San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, 5th floor

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HIV HEALTH SERVICES PLANNING COUNCIL
Minutes, February 7, 2000

I. Call to Order
3:30 PM

II. General Announcements
Bill Barnes announced that the Mayor had approved nine appointees for new two-year terms. The only nominee not approved was Donald Bliss. The Mayor's action was effective as of February 4th so the roll call was revised to include the new members. Margot Antonetty and Robert Teague are two of the nine new members. They were present at this meeting and took their seats. The other newly appointed people are Fernando Gomez-Benitez, Gary Harrell, Jeffrey D. Klausner, Carmen Madriz, Michael John Meehan, Gregory Neumark, and Robert Whitford. Mary Jane Wood was re-appointed.

III. Roll Call
Attachment A, Column 1. A quorum of the membership was present.

IV. Review and Approval of Agenda
Agenda accepted by consensus.

V. Public Comment

VI. Reports

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VII. Chief Financial Officer for the Department of Public Health
The Health Department is in the midst of preparing its budget for fiscal year 00-01. The deadline for submission to the Mayor is February 25th. Prior to that date, the budget will be discussed and further elaborated by the Health Commission. The Mayor has already given budget instructions to all city departments. He has said that the departments need to absorb salary COLAS (cost of living adjustments). The Health Department has approximately 6,000 employees, thus an estimated 3.5 COLA will add between $12 and $13 million. That cost must be added to the budget with no additional money coming from the General Fund. The other instruction was not to submit any program enhancements that would require additional General Fund contributions. In recent years, new programs were introduced. This year, the Mayor called for re-programming of existing resources to better meet the needs of the citizens served. He also suggested that the Health Department would need to offset any losses of state or federal funds with reductions in expenses, rather than ask for additional money from the City's General Fund. The Health Department is estimating a revenue drop of $20 million for next year. When combined with the employee COLAS and other cost increases, the overall shortfall comes to almost $40 million. The proposed remedy is called a "re-configuration of services." The resulting calculations still fall $18 million short of target, even after re-configuration.

MJW asked if there were any reductions of service in the area of AIDS care (beyond what the Council is already aware of—the CARE Title I funding reduction) resulting from the Dept. of Public Health budget problems. The answer was no. Additional questions were raised about the reported budget surplus from prior years. Yes, a $126 million surplus was reported, but almost all of this had to be put into this year's budget in order to make it balance. There will be significant reductions in federal contributions for the coming year, not just in the Ryan White CARE Act. Housing programs are taking a big hit (about $2.5 million), and Medicare funding has dropped as well.

VIII. HIV Health Services, Department of Public Health
Russ Zellers gave this report. This Planning Council had approved a Reductions Protocol designed to handle a reduction in the neighborhood of 2%. Instead, the Title I award was significantly less than had been planned for—a total reduction of about 3.3% or $1,144,056. RZ said that their proposal is to structure further reductions with the objective of minimizing the impact on service provision and clients.

He outlined the four levels of reduction already approved by the Council, and provided additional detail concerning the approximate figures in each level of reduction. A fifth level of reduction is now being proposed. This comes from the Planning Council's Support budget ($10,000). A sixth level has also been proposed, coming from the increase in Title II funds as an offset to the Title I decrease ($86,894). The next level that the AIDS Office is proposing is called "carry forward" funds from FY 98-99. This is an amount of money that was not approved by HRSA to be spent as San Francisco had requested, in order to set up a revolving fund for housing ($130,000). The last level that is being proposed for use in offsetting the cut in CARE Title I is "carry forward" funds from the fiscal year about to end, FY 99-00 ($549,403). This amount is the result of unspent funds that contractors leave on the table. The unexpended funds are usually higher than that. Questions arose about why a larger amount was not applied to offset the cuts. *Michelle Long Dixon* addressed this by saying that the HHS strategy is to not commit "one-time dollars" for use in offsetting cuts because those funds are not guaranteed to be available next year. The "carry forward" money from FY 98-99 is still available. HRSA did not like the proposal of a revolving fund for housing that had been included in the "rollover request" this year. Out of about $1.7 million, this is the amount not approved ($130,000) and available now.

The next question concerned using Title II funds as an offset. RZ explained that some programs could be transferred in order to generate savings in Title I. *GL* asked about the third and fourth levels. He is concerned that some providers may have had problems, but the service is still a necessary component of the system of care. *MLD* responded that these cuts generally do not mean closing down programs and ending these services, especially in the fourth level. There the proposed amount represents a loss to those contracts of around 33%. However, she said that the third level cut did result in the elimination of one program. *MS* asked about the rationale for not requesting San Mateo and Marin Counties to take a share of the cuts. The Title II funding used to offset the Title I cut only comes from the San Francisco amount, not the other two counties. It was confirmed that historically, the other two counties have been held harmless when it comes to funding cuts. *MS* compared one of the fourth level reductions to San Francisco services (in this case in the category of Mental Health) with allowing San Mateo County to have no Title I funding decrease. *Laura Thomas* responded that San Mateo County was experiencing an increase in the numbers of people affected by HIV and AIDS. That's why they had received a Title II increase in funding. Also, as the representatives from San Mateo and Marin have explained in the past, any reductions to their funding levels have a disproportionate impact because they pay for their systems of care with comparatively lower levels of funding. *NN* said that the other two counties should be given some time to prepare for projected cuts in future years. *SK* said that this year's proposal to HRSA looked excellent in his view, and yet the EMA was cut. To him, the trend is clear: that we need to be better prepared to work with less and be more realistic about the funding levels anticipated in future years. *MLD* agreed. She called for a planning process that deals with these challenges.

LCG brought to the Council's attention the cuts in outpatient mental health. She said that even though a particular contractor had not performed up to expectations, this service was still vitally needed in the community. *JM* questioned the fourth level of reduction and to what extent reductions in whole service categories would result in less service to clients and communities. *RZ* responded that the estimated cut in the specific service categories and programs (33%) would translate into real service reductions. The AIDS Office would negotiate with those contractors as to how this would be accomplished. *JM* asked about the monitoring reports as the basis for these reductions. *RZ* said these evaluations were done in the current year. The monitoring reports take into consideration many factors, including how well the contractor has responded to prior year's monitoring recommendations. *MLD* added that the fourth level cuts were very difficult for staff because these monitoring reports were completed at a time when no such cuts were thought to be necessary. These contractors were in the category of needing improvement, and this rating does not imply that they were not doing their job. Numbers are still approximate because there is discussion underway with these contractors. *JM* appreciated the response, and said it was very troubling from an ethical standpoint. How can we use such a monitoring process as a means by which we reduce services? He characterized this method as arbitrary. *RZ* said the AIDS Office had assessed that

33% was the reasonable rate of reduction in level four, but the Council can revise that percentage. *SS* then talked about a past contract for Infusion. She said there was $113,000 that was being used by an outpatient pharmaceutical company to provide services for two clients. The Council had decided not to fund that again. A task force worked on how to transfer those clients to other services or other providers. The debate continues, however, about the use of these funds for infusion therapy or for attendant care. The Steering Committee of the Council would like to recommend that this money be utilized in the service categories involved in the fourth level of reduction: primary care lab services, outpatient substance use, outpatient mental health and food. That way, the cuts in level four of the reductions protocol could be revised. *MD* asked about the second level of reduction and what was the nature of the under-utilization of contractual funds in the area of home health care. *RZ* said he thought it was due to staffing problems or high turnover of staff in a particular agency. He said he thought those problems had been remedied. It is not a residential housing facility, but rather care to individual clients in hotel housing. *JB* questioned the Council's procedure. If the reduction levels 1 through 4 had already been approved, why are we revisiting issues related to those areas? *SS* responded that clearly levels 1 through 3 had been approved, but she considers level 4 to be in a gray area because it is based on this year's monitoring reports and programs that received "Needs Improvement" ratings. *JB* asked that discussion focus on the levels beyond level four. *MS* felt that greater examination was necessary in relation to the four contractors identified as needing improvement (level 4 reduction). He said that this was the result of interpretation by the monitoring team and that these four contractors were in the four of the top six core or priority service categories. He did not want to make such cuts to mental health and other essential services. He preferred to cut from the bottom. Clarification was requested regarding the fifth level of reduction in the area of Planning Council Support. *SS* said the amount of $10,000 would be taken away from the effort to do a Client Satisfaction Survey, rather than the other areas involving staff support or the consumer rights advocate. This is viewed as a fair cut, but the Client Satisfaction Survey is still important and must be done. It will just have to done on a smaller budget.

IX. Implementation and Evaluation Committee Comment

Stephan Oxendine, one of this committee's co-chairs, said that the Council would be facing more discussions of this type in the future because more cuts would likely be forced in upcoming years. He said he agreed with Susan Shea's suggestion to use $113,000 in an effort to take less money from the four contractors identified in level four. However, he felt that this would only buy some time, and thereby postpones the moment when more difficult decisions have to be made.

SS asked if members of the public would like to offer their views on the issues under discussion by the Council. *Jim Illig* said the HIV Contractors Association had asked that the Council not make the cuts in the manner previously approved. He said that he would put one of the same suggestions back on the floor. For example, a 3% reduction to San Mateo and Marin Counties would result in savings of $100,000 in San Francisco services. Further, he pointed to the services such as direct emergency financial assistance to clients, and said some cuts should be made in that category rather than to the essential service categories.

SS asked for motions from Council members. *MJW* moved to approve the AIDS Office proposal with one exception—to incorporate the suggestion that $113,000 get put back into the level four reduction (per the plan offered earlier in the meeting by Susan Shea). Her motion was seconded. *MS* moved to substitute a further reduction in Planning Council Support for the remainder of the level four reduction. *SS* spoke against reducing Planning Council Support by a further $30,000. She said the Client Satisfaction Survey was very necessary to help make the future decisions concerning cuts in service categories, and she emphasized how important Technical Assistance is. However, there is no TA included in the Council's budget. *MS* then withdrew his amendment. Attention turned to the original motion by MJW. This motion passed by a vote of 16 yes, 3 no, and 2 abstentions (see attachments).

MS then made a motion to restore funding to the service categories in level four once the rollover request

had been approved. This motion was seconded. The four programs included in level four would be absorbing a 7% funding decrease under the motion just agreed to. Laura Thomas expressed the view that contract monitoring reports can be used to make decisions about funding cuts. She said the Council had approved this in principle. She also felt that the more that the Council shifts the burden of these cuts and uses "one-time/rollover" funding to offset cuts, the harder the decisions to be made in the future. *LCG* said she felt that the distinction some members were making between essential and non-essential services was not a distinction that individual clients always would be in agreement with. *SO* again voiced a note of caution about the future, wanting to retain as much flexibility about the rollover monies as we can. He also felt the Council was going back or reopening prior decisions. The way to avoid this in his view is for everyone to attend the meetings and put these views on the table. He does not want to revisit prior decisions. *GL* made the distinction again between specific programs and service categories. We may want to penalize some programs with the lower range of monitoring results, but it's another issue to take money out of categories where it is needed. *SS* said she felt that was a valid distinction and one that we would all need to be reminded about, but that it didn't help with the current decision about a reductions protocol. *MS* said he didn't want to focus only on the ways we reach decisions. He said our role was not just to vote on processes. We vote on priority service categories. And, he does not like chipping away at those services we had identified as being essential to clients: primary health care, housing, mental health services, substance use programs, and food. This may not be the time to have the argument about $29,000, but this money may never come back and we may be able to find other ways of accomplishing these savings. This is hard money to get; the services are more important than concepts about mortgaging our future flexibility. *Bill Barnes* also expressed concern about losing services in the areas of mental health and substance use. The McKinney cuts in housing are going to impact these service areas with further losses. He suggested that rather than shifting the burden of offsetting a $29,000 loss in these services to future rollover monies, we instead look at the option of making a less than 1% cut to San Mateo and Marin Counties. He felt there would be sufficient time for those counties to calculate ways of handling such a relatively small loss. *SS* called for members to speak directly to the motion on the table. *JM* spoke in favor of the motion. He said cutting primary services to people with HIV was not acceptable in a context of such a wealthy city overall. He said the motion would at least insure that future monies could restore these important services. He called this an acceptable strategy. *JB* felt that it would be unfair to make cuts to San Mateo and Marin Counties without their representatives being present. The question was called in order to end discussion of this motion. A vote was then taken on the motion to restore level four reductions through further use of future rollover money. The vote totals were 12 yes, 7 no, and 3 abstentions. This meant that the yes vote did not attain the two-thirds majority necessary for passage.

X. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence

Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

February 7, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	Y	N							
2. Alliena Baker	*AB*	P	Y	B							
3. Hazel Betsey	*HB*	P	Y	Y							
4. Donald Bliss	*DB*										
5. Jeff Byers	*JB*	P	Y	Y							
6. Bart Casimir	*BC*										
7. Veronika Cauley	*VC*										
8. Raymond Combs	*RC*	P		Y							
9. John Conley	*JC*										
10. Luis De La Torre	*LDT*										
11. Mark Dunlop	*MD*	P	Y	N							
12. Gregory Edwards	*GE*	P	Y	B							
13. Catherine Geanuracos	*CG*	P	Y	Y							
14. Fernando Gomez-Benitez	*FGB*										
15. Gene Gowdey	*GG*										
16. Laura Carcagno Guzmán	*LCG*	P	Y	N							
17. Gary Harrell	*GH*										
18. Siddiq Jihad	*SJ*	P	Y	Y							
19. Sam Kaplan	*SK*	P	Y	N							
20. Jeffrey Klausner	*JK*										
21. Gene London	*GL*	P	B	Y							
22. Carmen Madríz	*CM*										
23. Michael Meehan	*MM*										
24. Allen Meyer	*AM*										
25. Jim Mitulski	*JM*	P	N	Y							
26. Gregory Neumark	*GN*										
27. Norm Nickens	*NN*	P	Y	N							
28. Jorge Ortíz	*JO*										
29. Stephan Oxendine	*SO*	P	Y	N							
30. Ken Pearce	*KP*	P	Y	Y							
31. Alissa Riker	*AR*	P	Y	Y							
32. Nilda Rodriguez	*NR*										
33. Susan Shea	*SS*	P	Y	Y							
34. Mike Shriver	*MS*	P	N	Y							
35. Bob Teague	*BT*	P	B	B							
36. Al Terrazas	*AT*	P	N	Y							
37. Kelly Wallace	*KW*										
38. Robert Whitford	*RW*										
39. Eric Whitney	*EW*	P									
40. Mary Jane Wood	*MJW*	P	Y	N							

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

February 28, 2000

AGENDA

I.	**Call to order**	**5:00 PM**
II.	**Roll Call**	**5:02 PM**
III.	**Review and Approval of Agenda**	**5:04 PM**
IV.	**Review and Approval of Minutes,** 1/24; 2/7 — **VOTE**	**5:06 PM**
V.	**General Announcements**	**5:10 PM**
VI.	**Public Comment**	**5:15 PM**
VII.	**Reports**	
	• *Mayor's Liaison - Bill Barnes*	**5:25 PM**
	• *Steering Committee*	**5:30 PM**
	Welcome – New Members	
	Ryan White CARE Act Reauthorization	
	Council Support Contract	
	• *Implementation & Evaluation Committee*	**5:40 PM**
	Reggie Task Force — **VOTE**	
	Client Satisfaction Survey Working Group—Update	
	Six-month Workplan—Update	
	Minority AIDS Initiative (formerly CBC Initiative) — **VOTE**	
	• *PWA Caucus*	**6:20 PM**
	Mission Neighborhood Community Forum—Report	
Break		**6:30 PM**
	• *HIV Health Services*	**6:45 PM**
	• *Membership Committee*	**6:50 PM**
	Membership attendance requirements; Representation Issues — **VOTE**	
	• *Housing Committee*	**7:05 PM**
	HOPWA Loan Committee Representative — **VOTE**	
	Eviction Prevention Project—Presentation (Kevin Fauteux, Lutheran Social Svcs.)	
	• *San Mateo County Health Services*—Presentation	**7:25 PM**
	• *Marin AIDS Project*—Presentation	**7:40 PM**
VIII.	**New Business**	**7:55 PM**
IX.	**Adjourn**	**8:00 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Wed	3/1	Housing Committee	25 Van Ness, Room 330A	3:00 – 5:00 PM
Wed	3/1	PWA Caucus	25 Van Ness, Room 330B	5:30 – 7:30 PM
Thurs	3/2	Membership Committee	25 Van Ness, Room 330A	5:30 – 7:30 PM
Mon	3/6	Implementation & Evaluation Committee	25 Van Ness, Room 330B	5:00 – 7:00 PM
Mon	3/13	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Tues	3/14	Client Satisfaction Survey Working Group	25 Van Ness, Room 330A	4:00 – 6:00 PM
Mon	3/20	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Mon	3/27	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Tues	3/28	Client Satisfaction Survey Working Group	25 Van Ness, Room 330A	4:00 – 6:00 PM

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Motion to HIV Health Services Planning Council concerning Project Reggie, to be presented at February 28, 2000 Council meeting for consideration

"The HIV Health Services Planning Council supports a mandate of Project Reggie by the SFDPH for all CARE-funded agencies, if and only if:

- hardware, connectivity and personnel at the agency level be provided by the SFDPH and other funding sources;
- no CARE funds are used to support Project Reggie.

As per the 1995–1999 HIV Health Services Planning Council 5-Year Plan, Reggie must provide a universal client registration system and collect unduplicated client-level data when fully implemented."

Background information:

The director of the SFDPH, Mitch Katz, MD, approached the HIV Health Services Planning Council in December, 1999, and requested that the Council secure community input regarding a system-wide mandate of Project Reggie, and ultimately determine if the HIV Health Services Planning Council would support a mandate of the Project.

The Council convened a task force in January of this year to provide a venue for Council members, community members, contractors, SFDPH staff, and other interested parties to share their experiences, support, and concerns regarding a mandate of system-wide implementation of Reggie at CARE-funded agencies in the San Francisco EMA.

The purpose of the task force was to bring to the Planning Council, in February 2000, a motion of support or non-support of a SFDPH mandate for Reggie implementation, based on the collective input provided at the task force meetings.

The task force met a total of four times. The first two meetings were information-gathering sessions where the aforementioned parties provided input. The third meeting was of a smaller group of community members who crafted a draft of motion language (with consideration to the issues raised in the first two meetings) to present to the fourth, larger community meeting. The fourth and final meeting consisted, again, of Council members, community members, contractors, SFDPH staff, and other interested parties, who crafted the motion language presented above for the Planning Council's consideration.

HIV HEALTH SERVICES PLANNING COUNCIL
Minutes, February 27, 2000

I. Call to Order
5:00 PM

II. Roll Call
Attachment A; Column 1. A quorum of the membership was present. Nine new members were seated on the Council, with eight of them present for this meeting. Many at the table did not know each other. Thus, some time was taken to go around and have all members, both new and old, introduce themselves. Norm Nickens, who is resigning his position on the Council, was acknowledged for his years of participation.

III. Review and Approval of Agenda
Eric Whitney went over the agenda. It was accepted without revision, by consensus.

IV. Review and Approval of Minutes
01/24/00 Council Meeting Minutes and 02/07/00 Council Meeting Minutes – Motion to approve the 01/24/00 minutes agreed upon by consensus. Two abstentions were noted. On the minutes from 02/07/00, new member Jeffrey Klausner asked for clarification of the dates that recent appointments became effective, and whether non-attendance of the recent meeting would count against him, even though none of the new members had received their letters of appointment at that time. The answer was that no, that meeting will not be used to calculate attendance of the new members. The voting sheets associated with the two past meetings had not been sent as attachments in the mailing, but were available at this meeting on the front table. The minutes from 02/07/00 were then approved by consensus. Again, there were two abstentions.

V. Public Comment
Charlotte Bobek of the UCSF Positive Health Program spoke in favor of utilizing the Reggie computer system to track units of service. Their agency started using it during 1999, and is very satisfied. Lee Jewell, a client who is enrolled in the Reggie, thanked the Council members for their work on evaluating Reggie. He is also a client advocate, and spoke from his experience working with a range of clients who genuinely appreciate the Reggie system. It streamlines their access to services, and he thinks they would face some significant obstacles without it. Charlene Stamps-Balling, a Project Coordinator at CalPEP, introduced herself. Suzanne Pabalate read a statement that she also distributed. She works as a Reggie Systems Administrator at the Center for Special Problems and spoke from her personal experience about the startup of Reggie at her agency. *(see attachments).* Nick Wukich, from the San Francisco AIDS Foundation, also spoke in favor of Reggie. He worked as a member of the Planning Council's Reggie Evaluation Task Force, which recently held a series of meetings. He said he hoped Council members would evaluate all the information that had been forwarded from the Task Force. He said that a year ago, the Council had planned for a system that would obtain unduplicated client-level data and eliminate the repetitious registration process for clients. He feels that the Reggie has absolutely succeeded in meeting those objectives. He helped draft the language of the resolution that will be presented tonight, and urged all council members to support it.

Donald Bliss, Executive Director of *Full Circle Counseling* agency, said after much confusion he was finally certain that he was no longer a member of the Council. Thus, he was taking the opportunity to speak during the public comment time. He related the story of not receiving official notification from the Mayor's office about not being re-appointed. Similarly, he had not heard from the Council's Co-chairs. For the month of February, his status continued to be uncertain and in limbo. He heard on Feb. 27th (the date of this meeting) from the Mayor's appointments secretary, saying he had not been re-appointed in order to give other people the chance to serve. He felt they were being less than honest. He summarized his feelings as being disappointed and disgusted. Nonetheless, he said he wanted to continue supporting the work of the Council. Then, he spoke about a bylaws provision

related to reimbursements for expenses/lost wages. He would like to ensure that such reimbursements are available to Council members who are low-income people receiving services under the CARE Act. He spoke in favor of going beyond the stipends currently available.

VI. General Announcements

EW asked that Council members review a roster being passed around and make necessary updates to the information listed for each member. Those things requested are the basics of communication: address, organizational affiliations, telephone and e-mail. He asked everyone to verify that the current data is correct or, if not, to make corrections.

VII. Reports

VIII. Mayor's Office Liaison

Bill Barnes distributed a written report and presented comments. First, he clarified that the terms of new Council members began Feb. 5, 2000, even though the letters notifying new people didn't get mailed until later that week. He apologized for the confusion, then added that the confused mode applied to the letter sent to Donald Bliss as well. It had an incorrect zip code and wasn't received for that reason. Next, Bill Barnes welcomed the new members on behalf of the Mayor, adding that the Council was almost at its maximum membership of 40. He next mentioned the expanded Sunshine Ordinance (Prop. G from last year), which was approved by the voters and is now being implemented City-wide with the help of the City Attorney's office. The new rules translate into a number of public information procedural changes for the Council and require more record-keeping. He wants to ensure that the funding for this administrative work is found in a source other than the health service money that the Council must prioritize. Then, he mentioned the challenge coming from some individuals about the relationship between AIDS, the disease, and HIV, the virus. On this topic, he distributed two thorough research papers. Finally, he thanked the Council members who worked on the analysis and evaluation of Reggie, the computer system for centralized registration. He said that the Mayor is totally in favor of continuing with this system, encouraging everyone to vote in support of the resolution prepared for this meeting. He pledged that his office would work to find the resources for full implementation of Reggie, again not out of CARE money.

IX. Council Steering Committee Report

Siddiq Jihad gave a brief report about CARE Act Reauthorization. During the month of March, a big push will come from many sectors supporting reauthorization of the legislation known as the Ryan White CARE Act. He called for a community meeting on this topic and invited interested members of the Council to attend. The date selected was March 2nd at 3:00 PM. But, he invited others to offer alternate suggestions if that date wasn't good.

Eric Whitney gave an update on the Council support contract. The Council co-chairs would prefer that the clerical support staff be employed by another agency or contractor. In order to continue having people with HIV/AIDS in those jobs, the Council's co-chairs have been talking with the Positive Resource Center about taking over the contract. The details are still being ironed out. But, it is anticipated that the costs to the Council associated with these services will not increase. And, it is hoped that the change will result in more stability both for the clerical support employees and the Council. As soon as the details are finalized, a comprehensive Council Support budget will be forwarded to the Council, covering the fiscal year 2000-01.

X. Implementation and Evaluation Committee Report

Gene Gowdey, one of this committee's co-chairs, reminded everyone that it had been only eight weeks since Mitch Katz had made a presentation to the Council. At that time the Director of Public Health had explained the reasons why he felt he needed a community mandate and the Council's support in order to carry-on with the development of this unified registration system designed to report unduplicated client information. A Task Force was then established within the I&E Committee with the charge of hearing both sides of the issues and gaining community input

from both clients and contractors. This working group met for four sessions, which included a lot of lively discussion for and against the continuation of Project Reggie. A range of written reports came out of the Task Force's four meetings. Many of these were now being made available to the Council, because members may wish to consider some of the background information while deliberating the issues of this meeting.

GG said he had prepared a summary sheet, which attempts to illustrate the costs. He said it had been a difficult task to carry out the evaluation of Project Reggie, and it was made more difficult because the working group had to ask several times for cost analyses from the Dept. of Public Health. The problem apparently is that there are many variables, such as the size of agency operating this system and the implementation scenarios. He said that much of the discussion pro and con really boils down to the project's cost and funding. He then read the resolution that had been forwarded for consideration at this Council meeting from the members of I&E's Reggie Task Force *(see attachments)*. The language basically calls for the Council to give its support to the Project's continuation if the costs are fully borne by other sources. The necessary stipulation then is that the Council recommends no CARE funding be provided. The wording of the resolution is the product of a great deal of debate within the working group. *GG* expressed his reservations about the if/then wording, and explained that he worries about the possibility of facing some ambiguous funding scenarios, which could generate disputes in the future.

After his opening remarks, the first points of discussion sought to clarify language of the resolution. Next, *LCG* spoke about the overall financial climate that has resulted from reduced funding in the EMA's Title I award under the CARE Act. This situation has now been combined with budget reductions from the San Francisco General Fund for the coming year. The net result is severely reduced funds for the services of the Dept. of Public Health. In this climate, she feels that DPH will not be able to come up with the money for further development of Project Reggie, and she fears that eventually the only option left to DPH will be the option of taking money from other services. In sum, her concern is that this resolution sounds fine as a compromise, but the funding crunch may mean that we are adding to the budget pressures at DPH. *GH* asked how many clients would be served by the services of Project Reggie. *EW* replied that when fully implemented the system is supposed to include every client receiving services in San Francisco, regardless of the number of services or the agencies involved. *EW* then spoke in favor of the motion or resolution as written by the Task Force. He felt that the language presented here is the result of a community process that included four meetings and much discussion. There was a strong sense of agreement among all those giving their input that we need a system designed to provide universal client registration in San Francisco and to collect unduplicated client information. We need the information, and HRSA expects it. While not everyone in the Task Force supported this version of the motion, it got more support than any alternative approach. Reggie is generally viewed as a system that works. A lot of agencies are already using it. A lot of clients like it. The Council, in the past, provided some limited end-of-year funding, but the Reggie system has not been a line item in the health services budget. Under this motion, it won't be in the future. When the Director of Public Health spoke to us, money was not the issue. He wanted to know if the Council would support a mandate, in the event that DPH continued the development and decided to push more agency participation. *EW* said he believes the system will work even better when every agency in the city is actually using it. The motion also includes the recognition that implementing it will be more difficult at some agencies, therefore DPH is called upon to provide all the necessary support. He called for an individually tailored approach to identify those support needs, agency by agency. *JK* spoke in favor of the motion, saying that it encourages many individuals to feel more confident in their efforts to access services. With support from the Mayor, he thinks that the money will be found, beyond the current DPH budget, to support continued development of Reggie.

SO tried to get a better understanding of how the budget figures for starting up full-scale use of the system at three sample agencies could be so radically divergent. Terry Dowling of DPH

explained that one example, a mid-size agency, has higher costs of operation than a large provider, such as San Francisco General Hospital. This is because the large provider can attach units of service to each client contact and do so more efficiently within the Reggie system. Software had to be developed for this purpose. Thus, there was a higher up-front cost, but now an ease of operation that allows SFGH to save time and effort. Other agencies define their units of service differently and have a method that requires a second round of data entry in order to capture their units of service in a reportable format. *KP* asked about the Mayor's support for funding Project Reggie. Was his support as strong as just asserted? The Mayor's representative Bill Barnes held back from declaring full support for the precise language of the motion due to a very fluid set of dynamics shaping the city's budget. Bill believes the Mayor strongly supports the concept of universal registration, but since only certain kinds of "one-time" expenditure can get into the budget, any plans that imply new on-going costs would probably not be approved. Bill summarized by saying that he will be looking for sources of funding to enhance one-time projects. He will advocate for one-time projects related to implementation of Reggie in order to win budget approval.

JB asked for clarification of how the motion would impact clients in San Mateo and Marin Counties. *KW* spoke for Marin, saying he believes the county is responsible for tracking unduplicated client information. He would support mandating this as a responsibility and thinks such a policy could be implemented with cooperation from all six agencies providing services in the county. However, the costs associated with Reggie wouldn't make sense. *JC* spoke for San Mateo, saying that he had asked Mitch Katz for his views of this issue during the meeting in December. Thus, it was clear that the SF Director of Public Health is seeking a mandate on Reggie while respecting the separate systems of the other two counties in the EMA. *JC* pointed out that San Mateo does collect unduplicated client data already. He also pointed out that San Mateo currently has its own challenges in implementing new computer networks for county operations. He also said that Mitch Katz had clarified that the mandate he is seeking does not apply to the other two counties in the EMA, only to San Francisco. So, *JB* sought to include such a clarification in the motion on the table, referring to San Francisco's CARE-funded agencies. This was considered a friendly amendment to the language of the motion. No vote was necessary.

MJW spoke about other funding sources for Reggie as well as some of the real costs that service providers incur from the operation of the Reggie system. She put forward what was called a compromise motion, in an attempt to make the impact of a Council mandate clearer and to be realistic about funding. The motion language called for financial support be addressed at the agency level beyond those the agencies are already expected to incur to implement the Reggie system at their agency. This amendment was then voted on. It received 15 yes votes, 14 no votes, and 2 abstentions. Thus, it did not reach the two-thirds required for passage. *(See Roll Call Sheet, Column 2)* Next, there were arguments for and against the original language of the motion as written. The vote on that one was 17 yes, 10 no, and 4 abstentions. Thus, it also failed to gain the two-thirds vote required for approval.

Next, *SS* put forward a motion to explicitly not support a mandate of Project Reggie, stating her view that the Director of Public Health asked the Council to make a decision about mandating Reggie, or not. To her, that is the only question. She wanted to know if it's the language of the particular motion that had come from the Task Force that the Council is against, or if it's the entire concept of mandating Reggie that is generating opposition. *KW* expressed his view that what works about Reggie is universal client registration and unduplicated client information. Without the mandate, you don't get those advantages. We need to support it fully in order to get the desired results. *SO* said he believes the Reggie system is needed and we need a process to get it completely up and running. At the moment it's just available to some clients on a selective basis. *GG* said he believed there was a lack of financial information to vote in favor of the original motion, so he was going to vote in favor of this one to explicitly not mandate. He viewed this motion as an endorsement of the status quo, allowing for a variety of ways to count

unduplicated clients. He mentioned free software that was being distributed by HRSA. Then a vote was taken on this motion that the Council does not support a mandate for Project Reggie. It obtained 2 yes votes, 22 no votes and 7 abstentions.

EW asked that staff members from DPH add some clarification to the time constraints that they're working under with regard to Project Reggie. In other words, he asked staff to explain why it's important that this issue be resolved in this meeting. Terry Dowling spoke from the staff point of view saying that there have been two major funding sources for Reggie: the U.S. Dept. of Commerce and HRSA. Both of those require that any budget revisions be submitted six months before the end of the contract year. That leaves about four weeks for staff to prepare those necessary revisions that are to be based on the outcome of this vote by the Council, and thereby retain the funding currently being received.

Next, *SS* made a motion that the HIV Health Services Council supports a mandate for Project Reggie (Period!). *VC* spoke about the positive effect on many clients from the registration capacity of Reggie because it gives them greater access to services. She advocated not pulling the rug out from under this effort after the high investment represented by both time and money. *GL* asked for clarification as to the consequences of not passing any motion for or against a mandate. *EW* said that he felt we were being asked to support a department of public health mandate of Project Reggie. The Department has said that they won't attempt to continue implementing it, unless they do receive a community mandate, a significant expression of which comes from this Council. *GL* asked how much had been spent, to date, on Project Reggie. DPH responded that the total from all funding sources is $3.4 million. *EW* took the view that the job of the council is not to oversee the budget of this DPH project (especially with no CARE funds currently involved), but to establish priorities such as universal client registration and unduplicated client data. This system works well when it's implemented. He said that these priorities have been in place for a number of years because the Council has consistently voted to make access to services, one of its top priorities. *SO* added his support based on recalling the words of Mitch Katz to the effect that Reggie had gone as far as it can go without a mandate. The amount of CARE dollars invested in the past has been insignificant compared to the other independent sources of funding that the system has. Dr. Katz said he needs our support so he can move forward. *KP* countered that we are also sending the message to all CARE-funded agencies that, if you want to continue receiving CARE dollars, you better get onboard. His understanding is that DPH wanted to help agencies develop their capacity to use Reggie; now we're potentially saying that this mandate comes with no guarantees of assistance because the motion is now so few words. Some agencies have resisted for precisely that reason. They want their limited funds to go directly to clients and services. *EW* asked staff for clarification of what implementation costs are borne by the agency. DPH responded that they presently have funding to provide one computer per agency. They also lend staff to do the data entry at the beginning; then when the agency starts it up, all their current clients are already on the system. Staff members at DPH and the Support Center believe they work continuously with agency staff on this effort.

Next, a roll call vote had to be taken on closing debate. It passed by a vote of 16 yes, 4 no, and 10 abstentions. *(See Roll Call Sheet, Column 5)* That meant moving immediately to a vote on the motion to simply support a mandate for Project Reggie, with nothing additional. This motion obtained 14 yes votes, 10 no votes and 6 abstentions. Thus, it failed to get two-thirds support. *(See Roll Call Sheet, Column 6)* *EW* expressed a desire to send the whole thing back to committee. *KW* reiterated that more than 10 hours of community meetings took place before the issue came before the Council; thus, it won't accomplish anything if we send it back to the I & E Committee for another round. A majority now wants to support a mandate in some form or fashion. Clearly, past Council priorities have included client's universal registration, and it doesn't seem like it's asking too much to attain the appropriate level of accountability by being able to say how many people we're serving.

Bill Barnes said that he had recently been involved in the city's budget process, trying to find money for the restoration of over $1 million lost from the DPH budget. Money issues are certainly important. All the Reggie money from Commerce and HRSA will leave the budget after about six more months if the council doesn't give its support, since those funds were exclusively for Reggie. At that point, we will still have to collect client data. *GG* and others expressed that the Council was not getting anywhere. Every side of the issue had been considered. The only thing left to do is say sorry, we couldn't come through with anything on this. *SO* said no to the idea of sending this issue back to the I&E Committee. Speaking as one of the committee's co-chairs, he's not interested in having the issue back. *JB* put forward a motion to support a mandate by a simple majority vote. But, it was realized that the Council cannot amend its bylaws on the fly. It's not in the spirit of the bylaws. Then, Yvette Flunder from the Arc of Refuge put forward language intended to break the Council's stalemate. She suggested simply supporting a mandate, while adding language to postpone implementation until all agencies have adequate capacity to come onboard. This didn't fly either.

Gene London stepped forward as a council member who didn't want the CARE dollars spent this way, still the discussion in this meeting had given him a better understanding of the budget and that, in fact, a relatively low percentage had come from past year's CARE budgets. Therefore, he wanted to call for a re-vote on the motion that came from the committee. It was clarified that a member who wished to change his vote (after obtaining new information) was permitted to call for re-consideration. That's the only way to take a second vote on the same thing in the same meeting. This motion for re-consideration was seconded. *KP* said he thought some members would look at the issue differently now. The original motion was re-read and voted on again. This time it got 22 yes votes, 4 no votes, and 3 abstentions. Thus, it carried with more than the necessary two-thirds majority.

More business was required, but the meeting was nearing its time limit for City Hall. The presentations had to be postponed. Finishing required business meant two additional votes that had to be taken out of order. Members voted to change the agenda by a show of hands (2 voted no, I abstained, all others voted yes). The first of these votes centered on approving a Council representative to the Loan Committee of HOPWA (Housing Opportunities for People with AIDS). Alliena Baker cannot continue as that representative. Catherine Geanuracos had agreed to be the new representative, if approved by the Council. This vote was also taken by a show of hands. No Council member voted no, and there was one abstention. All others voted in favor. Thus, her nomination to the HOPWA Loan Committee was approved unanimously.

The final issue of the meeting dealt with the Minority AIDS Initiative, which was known last year as the Congressional Black Caucus Initiative. The issue is how to allocate funding for the fiscal year starting March I, 2000, so that the money can be put into contracts as soon as possible. It is the recommendation of the I&E Committee $220,622 out of the $365,178 awarded to the San Francisco EMA as part of the Minority AIDS Initiative award for FY2000-2001 be prioritized to fund Treatment/Peer Advocate positions. The added funds will target the following populations: African American and Latino Transgenders, African American women in the Bayview-Hunter's Point area, mono-lingual (Spanish) Latinos/as, and Native Americans. The committee further recommends that all people funded for the positions of Treatment/Peer Advocate under this initiative must successfully complete the treatment education certification program training, participate in ongoing monthly workshops, and complete the community health outreach worker certificate training. Discussion opened with *JC* asking what the impact is on the counties (San Mateo & Marin), since these funds are coming to the EMA as a whole, not to San Francisco. Last year, these funds were used to support a program for people being released from prison and residing in any one of the three counties. The response was that there had not been discussion in committee about trying to serve people who live outside the targeted communities in San Francisco. The funded positions would be very difficult to split up, since there is one Treatment/Peer Advocate for each target population group. However, the Transgender program

could figure out ways to serve people from outside San Francisco. Then, *JC* spoke against the motion as presented because it seems to ignore those same population groups living in the EMA but outside of San Francisco. *VC* supported this proposed initiative addressing the needs of Transgenders, currently among the most under-served populations.

It was clarified that if the Council waited until the next meeting to vote on this motion, it would put the planning process and the official communications with HRSA too far behind schedule. Michelle Long Dixon, Director of DPH's HIV Health Services Division said that delaying the vote by a month would mean risking a cut to the award, because the contractors wouldn't have adequate time and HRSA may reduce the funding accordingly. This is the opportune time to get this effort moving. Negotiations will have to begin immediately with the appropriate providers, and there may be possibilities of gaining coverage of the other counties in the EMA during those negotiations. *FGB* said that he would like to see East Palo Alto in San Mateo County and possibly Marin City in Marin County served by this program. *SK* favored immediate implementation of the plans in order to retain the full funding. That means helping make the negotiation process with providers as smooth as possible. *MLD* expressed the view that the Council should have some full discussion, proactively, as to what are its priorities for targeted services to people of color communities. That way, when funding goes up or down, there is a basis on which to make decisions. A plan should be in place.

EW explained that these issues had been discussed in the I&E Committee, somewhat making up for the time crunch everyone is experiencing in this meeting. *SS* spoke up to say that the I&E Committee had received short notice about tackling this prioritization of new funds. They did some very productive work in a short amount of time, and she would have liked to see more members give their input at the committee. *MJW* suggested passing this motion, but made an amendment that the reference to the Bayview-Hunter's Point area be taken out, thereby allowing DPH to negotiate the particular details with cross-county flexibility. Motion to amend was seconded. *VC* spoke in favor of Bayview-Hunters Point receiving this service. Despite her desire to serve everybody, sometimes that can't be accomplished. The question was called on the amendment. *MJW* added that Bayview-Hunter's Point could still be targeted, but the specificity would be taken out of the motion in order to give some broader consideration after this vote, if needed. A Roll Call Vote was taken on calling the question. It passed 22 yes, 2 no *(see Roll Call Sheet, Column 8)*. Next, a vote was taken on the amendment, which removes the reference to Bayview-Hunter's Point from the language about serving African American women. The resulting vote was 10 voting yes and 14 voting no *(See Column 9)*. Thus, it failed.

Next, the Council moved to vote on the original recommendation from the committee. The vote was as follows: 18 yes, 5 no *(See Column 10)*. Thus, it passed with two-thirds majority.

XI. The meeting was adjourned.

Attachment A.

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

February 28, 2000		[1]	[2]	[3] org.	[4] 55	[5] roll q	[6] 55+	[7] org Rep	[8] call question	[9] amendment	[10] CBC
1. Margot Antonetty	*MA*	P	Y	Y	B	B	B	Y	Y	N	Y
2. Alliena Baker	*AB*										
3. Hazel Betsey	*HB*	P	Y	N	N	Y	Y	Y	Y	N	Y
4. ~~Donald Bliss~~	*DB*	P									
5. Jeff Byers	*JB*	P	Y	N	N	Y	Y	B			
6. Bart Casimir	*BC*										
7. Veronika Cauley	*VC*	P	Y	Y	N	Y	Y	Y	Y	N	Y
8. Raymond Combs	*RC*	P	N	B	N	Y	N	Y	Y	N	Y
9. John Conley	*JC*	P	Y	Y	N	Y	Y	Y	Y	Y	N
10. Luis De La Torre	*LDT*										
11. Mark Dunlop	*MD*	P									
12. Gregory Edwards	*GE*	P	B	B	B	B	B	B			
13. Catherine Geanuracos	*CG*	P	Y	Y	N	Y	Y	Y	Y	N	Y
14. Fernando Gomez-Benitez	*FGB*	P	N	B	N	B	N	Y	Y	Y	Y
15. Gene Gowdey	*GG*	P	N	Y	Y	N	N	Y			
16. Laura Carcagno Guzmán	*LCG*	P	N	N	N	B	N	N	Y	N	Y
17. Gary Harrell	*GH*	P	N	Y	N	Y	Y	Y	Y	Y	N
18. Siddiq Jihad	*SJ*	P	Y	N	N	B	N				
19. Sam Kaplan	*SK*	P	N	Y	B	N	B	Y	N	N	Y
20. Jeffrey Klausner	*JK*	P	Y	Y	N	Y	Y	Y	Y	Y	Y
21. Gene London	*GL*	P	N	N	B	N	B	Y	Y	Y	Y
22. Carmen Madríz	*CM*	P	N	Y	N	B	B	Y	Y	N	Y
23. Michael Meehan	*MM*	P	N	Y	N	B	Y	Y	Y	Y	Y
24. Allen Meyer	*AM*	P	Y	Y	Y	Y	N	Y	Y	Y	N
25. Jim Mitulski	*JM*	P	Y	Y	N						
26. Gregory Neumark	*GN*	P	B	B	B	B	B	B	Y	N	Y
27. Jorge Ortíz	*JO*	P	N	N	B	B	N	N			
28. Stephan Oxendine	*SO*	P	Y	N	N	Y	Y	N	N	N	Y
29. Ken Pearce	*KP*	P	N	Y	N	Y	N	Y	Y	Y	Y
30. Alissa Riker	*AR*	P	Y	Y	N	Y	Y	Y	Y	N	
31. Nilda Rodriguez	*NR*										
32. Susan Shea	*SS*	P	N	Y	N	Y	Y	Y	Y	N	Y
33. Mike Shriver	*MS*										
34. Bob Teague	*BT*										
35. Al Terrazas	*AT*	P	N	N	N	Y	N	N	Y	Y	Y
36. Kelly Wallace	*KW*	P	Y	Y	N	N	Y	Y			
37. Robert Whitford	*RW*	P	Y	N	B	B	N	Y	Y	N	N
38. Eric Whitney	*EW*	P	N	Y	N	Y	Y	Y	Y	N	Y
39. Mary Jane Wood	*MJW*	P	Y	N	N	Y	Y	Y	Y	Y	N
			2 A 15 Y	4 A 17 Y		10 A 16 Y	6 A 14 Y	3 ab 22 Y		10 Y	18 yes

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

March 27, 2000

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 2/28 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *Mayor's Liaison - Bill Barnes*	**4:55 PM**
	• *Steering Committee*	**5:05 PM**
	Abstentions/Conflict of Interest	
	Parliamentarian	
	Council Support Contract	
	CARE Act Reauthorization	
	• *Housing Committee*	**5:20 PM**
	Eviction Prevention Project—Presentation (Kevin Fauteux, Lutheran Social Services)	
	• *San Mateo County Health Services*—Presentation	**5:40 PM**
Break		**6:00 PM**
	• *SFDPH, HIV Health Services*	**6:15 PM**
	• *Marin AIDS Project*—Presentation	**6:30 PM**
	• *PWA Caucus*	**6:50 PM**
	Castro Neighborhood Community Forum	
	• *Membership Committee*	**7:00 PM**
	New Member Orientation	
	Membership Attendance—Update	
	• *Implementation & Evaluation Committee*	**7:05 PM**
	Un-funds Working Group—Update	
	Client Satisfaction Survey Working Group—Update	
	Six-month Workplan—Update	
	Prioritization—Update	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Mon	4/3	Un-funds Working Group	25 Van Ness, Room 330A	4:00 – 5:00 PM
Mon	4/3	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Tues	4/4	Client Satisfaction Survey Working Group	25 Van Ness, Room 330A	4:00 – 6:00 PM
Wed	4/5	Housing Committee	25 Van Ness, Room 330A	3:00 – 5:00 PM
Wed	4/5	PWA Caucus	25 Van Ness, Room 330B	5:30 – 7:30 PM
Thurs	4/6	Membership Committee	25 Van Ness, Room 330A	5:30 – 7:30 PM
Mon	4/10	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	4/17	Un-funds Working Group	25 Van Ness, Room 330B	4:00 – 5:00 PM
Mon	4/17	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Mon	4/24	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

HIV Health Services Planning Council, 1540 Market Street #301, San Francisco, CA 94102
San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, 5th floor

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HIV Health Services Planning Council
Minutes, March 27, 2000

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MAY 19 2000

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I. Call To Order
4:30 PM

II. Roll Call
Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Agenda approved. One abstention.

IV. Review and Approval of Minutes (VOTE)
EW asked for home addresses of members to possibly receive their Council package quicker. *SO* asked that a correction be noted in the IEC February Report minutes – the dollar amount for the CDC Minority AIDS Initiative should read $156,000. SJ motioned for the approval of 2/7/00 Council Minutes. Minutes approved.

V. General Announcements
JM announced the AIDS Memorial meeting on 4/22. This year's focus will be on the African-American community. *MLD* introduced Steve K from the Prevention Department Director in Department of Public Health.

VI. Public Comments
No public comments were recorded.

VII. Reports

Mayor's Liaison Report
- *Bill Barnes*, Mayor's Office liaison, is in Sacramento. No report recorded.

Steering Committee Report
- Abstentions/Conflicts of Interest. - *SJ* stated that Co-Chairs spoke with the City Attorney regarding Prop. G and Abstentions/Conflicts of Interest. More information was needed for clarification but a consensus was that vote abstention for disliking a subject was viewed as a violation of the By-Laws. *EW* stated that it was believed that the only true reason to abstain was for conflict of interest. Council can call members to declare their conflicts of interest if abstaining from a vote. But the proper way to protest a vote was to vote "NO", not to abstain. *EW* passed out Conflict of Interest forms for Members to fill out and return by meeting's conclusion.
- Parliamentarian. – *EW* announced that *JB* would be the Council's parliamentarian starting next month. *JB* spoke briefly of his experiences in various types of meetings involving parliamentary procedures.
- Council Support Contract. – *EW* reported that the new Support budget is not available due to pending changes in contracts.
- CARE Act Reauthorization. – *SJ* reported that this subcommittee group will meet on this Thursday, 425 7th Street at 5PM. *LT* spoke about the CARE Act movement in the political process. She reminded members, individual have a right to engage representatives, but as a Council it was important to educate representatives about community needs. LT stated that representatives should hear success stories of HIV and/or people of color using CARE-funded services in San Francisco. She alerted Council to a potential change in cost methodology as a "hold harmless" clause that if removed may cause a loss of funds to San Francisco.

Housing Committee Report
- *Kevin Fauteux*, Lutheran Social Services gave a presentation on the Eviction Prevention Project.

San Mateo County Health Services Presentation
- *JC* gave a presentation of the state of the HIV/AIDS epidemic in San Mateo County.

SFDPH, HIV Health Services Report

- *MLD* reviewed the AIDS Office's 3rd Quarter Report.

Marin AIDS Project Presentation

- *KW* introduced *Karin Whitfield*, Director of Outreach Services in Marin County. She presented information about the state of HIV/AIDS epidemic in Marin County. *KW* reported that in this county confidentiality is a big challenge.

Implementation & Evaluation Report

- Unfunds Working Group – Update. – *SO* reported on the progress of the Unfund Working Group. He expected to have guidance language for Council vote by 4/22.
- Client Satisfaction Survey Working Group – Update. – *SO* reported that a meeting was held regarding the Client Satisfaction Survey Working Group…It was felt that the current process was too cumbersome with contractors' specific information. *SO* stated that an independent process could move forward, looking at categories. i.e., case management, project are and integrated service.
- Six-Month Work Plan – Update. – IEC co-chairs will meet to work on recommendation language for 6/26th Council Meeting
- Prioritization – Update. – *SO* reported that the IEC has been working from last year's prioritization process, going through by service categories. The process is expected to be completed by 5/15/00. *SO* stated those if Council members are interested in a specific category attend that category specific meeting as listed in the IEC Schedule 2000 Overview.

PWA Caucus Report

- Castro Neighborhood Community Forum. - *JM* reported on a low turnout at the Mission Community Forum. There were questions regarding why there was such a low turnout at the people of color forums. HE felt that perhaps that after the Castro Community Forum, which was situated in a traditionally perceived HIV affected and savvy neighborhood some deductions could be made. *JM* stated that the next two forums are tentatively 4/25 in the Tenderloin and 5/23 in the Western Addition.

Membership Committee Report

- New Member Orientation. – *LCG* reported on the New Member Orientation and the Prioritization trainings.
- Membership Attendance – Update. - *LCG* reported that *NR* and *LDT* resigned for health reasons. She reported that two members have been retained for three months with minimal attendance and that *BC* has been extended a few months' suspension.
-

VIII. New Business

VC announced that there was a transgender position open at Black Coalition on AIDS.

IX. Adjourn

7:30 PM

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

March 27, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Alliena Baker	*AB*	A									
3. Hazel Betsey	*HB*	P									
4. Jeff Byers	*JB*	P									
5. Bart Casimir	*BC*	P									
6. Veronika Cauley	*VC*	P									
7. Raymond Combs	*RC*	A									
8. John Conley	*JC*	P									
9. Luis De La Torre	*LDT*	A									
10. Mark Dunlop	*MD*	P									
11. Gregory Edwards	*GE*	P									
12. Catherine Geanuracos	*CG*	P									
13. Fernando Gomez-Benitez	*FGB*	P									
14. Gene Gowdey	*GG*	P									
15. Laura Carcagno Guzmán	*LCG*	P									
16. Gary Harrell	*GH*	P									
17. Siddiq Jihad	*SJ*	P									
18. Sam Kaplan	*SK*	P									
19. Jeffrey Klausner	*JK*	P									
20. Gene London	*GL*	P									
21. Carmen Madríz	*CM*	P									
22. Michael Meehan	*MM*	P									
23. Allen Meyer	*AM*	P									
24. Jim Mitulski	*JM*	P									
25. Gregory Neumark	*GN*	P									
26. Jorge Ortíz	*JO*	P									
27. Stephan Oxendine	*SO*	P									
28. Ken Pearce	*KP*	A									
29. Alissa Riker	*AR*	P									
30. Nilda Rodriguez	*NR*	A									
31. Susan Shea	*SS*	P									
32. Mike Shriver	*MS*	A									
33. Bob Teague	*BT*	P									
34. Al Terrazas	*AT*	A									
35. Kelly Wallace	*KW*	P									
36. Robert Whitford	*RW*	P									
37. Eric Whitney	*EW*	P									
38. Mary Jane Wood	*MJW*	P									

22
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4/24/00

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

April 24, 2000

AGENDA

I.	**Call to order**	4:30 PM
II.	**Roll Call**	4:32 PM
III.	**Review and Approval of Agenda**	4:34 PM
IV.	**Review and Approval of Minutes, 3/27 — VOTE**	4:36 PM
V.	**General Announcements**	4:40 PM
VI.	**Public Comment**	4:45 PM
VII.	**Reports**	
	• *Mayor's Liaison - Bill Barnes*	4:55 PM
	• *T.O.D. Heroin Committee*—Presentation by Jennifer Friedenbach	5:00 PM
	• *San Francisco Needs Assessment Supplement*—Presentation by Harder & Company	5:20 PM
	• *SFDPH, HIV Health Services*	5:50 PM
Break		6:00 PM
	• *SFDPH Epidemiology*—Presentation by Willie McFarland	6:15 PM
	• *Steering Committee*	6:35 PM
	Resignation & Open nominations	
	Council Support Budget	
	5-year Strategic Planning	
	• *Housing Committee*	6:45 PM
	Un-funds—VOTE	
	• *PWA Caucus*	6:55 PM
	• *Membership Committee*	7:05 PM
	Clarification of Committee attendance	
	New Member Nominations—VOTE	
	• *Implementation & Evaluation Committee*	7:15 PM
	Un-funds Working Group—Update	
	Client Satisfaction Survey Working Group—Update	
	Cost Caps Working Group	
	Prioritization—Update	
VIII.	**New Business**	7:25 PM
IX.	**Adjourn**	7:30 PM

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Upcoming meetings:

Day	Date	Type	Location	Time
Mon	5/1	Un-funds Working Group	25 Van Ness, Room 330A	4:00 – 5:00 PM
Mon	5/1	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Tues	5/2	Client Satisfaction Survey Working Group	25 Van Ness, Room 330A	4:00 – 6:00 PM
Wed	5/3	Housing Committee	25 Van Ness, Room 330A	3:00 – 5:00 PM
Wed	5/3	PWA Caucus	25 Van Ness, Room 330A	5:30 – 7:30 PM
Thurs	5/4	Membership Committee	25 Van Ness, Room 330A	5:30 – 7:30 PM
Mon	5/8	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	5/15	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Tues	5/16	Client Satisfaction Survey Working Group	25 Van Ness, Room 330A	4:00 – 6:00 PM
Mon	5/22	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

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OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

REPORT TO THE SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL

Bill Barnes, Advisor to the Mayor on AIDS and HIV Policy
February 28, 2000

WELCOME TO NEW COUNCIL MEMBERS

On behalf of Mayor Brown, I am pleased to welcome the newest members of the Council. Mayor Brown is certain that Margot Antonetty, Fernando Gomez-Benitez, Gary Harrell, Jeff Klausner, Carmen Madriz, Michael John Meehan, Greg Neumark, Bob Teague, and Robert Whitford will be great additions to the Council. In addition, Mary Jane Wood has been reappointed and Mayor Brown is appreciative of her continued service.

PROPOSITION G IMPLEMENTATION

As you know, San Francisco voters approved Proposition G, a measure to expand the City's Sunshine Ordinance. This measure calls for additional steps to ensure that the public has access to all documents pertaining to business conducted by departments, agencies, commissions and public officials in San Francisco. These steps include posting of agendas and other materials on the Internet, development of "records retention" policies and a new Records Index to be compiled by the City Administrator. In the coming weeks, the Mayor's Office will convene a meeting to determine how to best implement these new requirements with regard to the HIV Health Services Planning Council, and how these new staff functions will be attributed.

THE RELATIONSHIP BETWEEN THE HUMAN IMUUNODEFICIENCY VIRUS AND THE ACQUIRED IMMUNE DEFICIENCY SYNDROME

Recently, some AIDS revisionists have questioned the cause of AIDS, specifically claiming that HIV does not cause AIDS. For your information and reference, I have attached two documents: a hotline handout from Project Inform and a thorough analysis from the National Institutes of Health. I hope you find them informative.

If you have questions on these or other items, please call me at (415) 554-5950.

MAYOR'S OFFICE OF AIDS & HIV POLICY
CITY HALL—ONE DR. CARLTON B. GOODLETT PLACE, ROOM 475, SAN FRANCISCO, CALIFORNIA 94102
(415) 554-5950, FAX (415) 554-5955
RECYCLED PAPER

City and County of San Francisco

Department of Public Health

CENTER FOR SPECIAL PROBLEMS
1700 Jackson Street
(Between Van Ness & Franklin)
San Francisco, CA 94109
Phone: (415) 292-1500
FAX: (415) 292-2030

Date: February 28, 2000

To: HIV Health Services Planning Council

From: Suzzanne Pabalate

Re: Reggie

My name is Suzzanne Pabalate. I am the Reggie Systems Administrator at the Center for Special Problems. I would like to share with you my personal experience transitioning into Reggie. Prior to Reggie, I was required to enter our programs units of service and unregistered UOS into a database that had zero ability to produce reports for UOS or client demographics. All HRSA and end of month reports had to be hand tabulated.

When CSP first converted to Reggie (Mid May 1999), I experienced learning curves (or growing pains) that were cumbersome and at times frustrating. All of our forms had to be revised, charts updated, all of our clients had to be input into the database, train clinicians how to complete these forms with the clients as well as enter billing daily. I had sole responsibility for all of these tasks as well as my other daily responsibilities at CSP. There were many times that I felt that it was easier to track our UOS the "old way" instead of going through these changes.

We are now 3/4's into our first year of being "LIVE" with Reggie and I have found that the ease of entering billing, the variety of ways to extract UOS, Unregistered UOS as well as client demographics for all reports required of our program and the technical support offered is remarkable. The most frequent problem that I experience today are finding inconsistent or incomplete client information from an agency that should have entered data and for some reason failed to do so. This lack of information often creates duplication of paperwork for clients and agencies. We might begin to avoid some of these problems if Reggie were mandated for all agencies serving the HIV community. Thank you.

Motion to HIV Health Services Planning Council concerning Project Reggie, to be presented at February 28, 2000 Council meeting for consideration

"The HIV Health Services Planning Council supports a mandate of Project Reggie by the SFDPH for all SF CARE-funded agencies, if and only if:

- hardware, connectivity and personnel at the agency level be provided by the SFDPH and other funding sources;
- no CARE funds are used to support Project Reggie.

As per the 1995–1999 HIV Health Services Planning Council 5-Year Plan, Reggie must provide a universal client registration system and collect unduplicated client-level data when fully implemented."

Background information:

The director of the SFDPH, Mitch Katz, MD, approached the HIV Health Services Planning Council in December, 1999, and requested that the Council secure community input regarding a system-wide mandate of Project Reggie, and ultimately determine if the HIV Health Services Planning Council would support a mandate of the Project.

The Council convened a task force in January of this year to provide a venue for Council members, community members, contractors, SFDPH staff, and other interested parties to share their experiences, support, and concerns regarding a mandate of system-wide implementation of Reggie at CARE-funded agencies in the San Francisco EMA.

The purpose of the task force was to bring to the Planning Council, in February 2000, a motion of support or non-support of a SFDPH mandate for Reggie implementation, based on the collective input provided at the task force meetings.

The task force met a total of four times. The first two meetings were information-gathering sessions where the aforementioned parties provided input. The third meeting was of a smaller group of community members who crafted a draft of motion language (with consideration to the issues raised in the first two meetings) to present to the fourth, larger community meeting. The fourth and final meeting consisted, again, of Council members, community members, contractors, SFDPH staff, and other interested parties, who crafted the motion language presented above for the Planning Council's consideration.

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4/24/00

HIV HEALTH SERVICES PLANNING COUNCIL
April 24, 2000

Minutes

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I. Call to Order
4:40 PM

II. Roll Call
Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
It was accepted without revision, by consensus.

IV. Review and Approval of Minutes
03/27/00 Council Meeting Minutes – A misspelling on the name of one presenter was noted, and corrected. Motion to approve the 03/27/00 minutes was agreed upon by consensus.

V. General Announcements
Bob Teague reminded members about the Transgender Health Care Conference scheduled to take place in San Francisco on May 5, 2000. It is sponsored by the AIDS Education & Training Center in partnership with the SF Department of Public Health. About 200 people are expected at this groundbreaking conference. *Veronika Cauley* noted that materials such as the regular Quarterly AIDS Surveillance Report were still being issued by SF-DPH without proper inclusion of Transgender statistics. She noted the problems associated with this omission and said that she had contacted the Director of Public Health, Mitch Katz, about this issue. He has committed to re-examining all Department publications in an effort to gain the appropriate diversity related to gender and gender identity.

VI. Public Comment
Brad Hume introduced himself as a prospective Council member whose nomination is before the Council for a vote during this meeting. He highlighted his background in housing rights advocacy work as well as his overall volunteer efforts. *Janis Takamoto,* another Council nominee, also introduced herself. Her background is in social work, and currently she is employed at San Francisco General Hospital's Ward 86. *Kelly Wallace* announced that the Marin AIDS Project is seeking applicants for the position of Director of Client Services.

VII. Reports

Mayor's Office Liaison
Bill Barnes presented the announcement of his resignation from the Mayor's staff. April 30th, 2000 was to be his last day before moving over to a job at the Neighborhood Parks Council, a part of the Department of Parks and Recreation. He thanked everyone who he had the opportunity to work with. He talked about the San Francisco budget situation, saying that there is still time to issue appeals for General Fund allocations to HIV Health Services, Mental Health and other potential projects. *Siddiq Jihad* asked Bill about getting a meeting set up again between the Council Co-chairs and the Mayor. Bill apologized for the recent cancellation, and he added that one potential way to get a meeting with the Mayor would be to collaborate with Dr. Katz, who has a regularly scheduled meeting set up for every second Friday. *SJ* also asked about how the Mayor's staff would be involved in advocacy work on the CARE Act's Reauthorization. Bill mentioned Colleen Johnson as the City's overall coordinator and Karen Carlson as the Mayor's federal affairs manager who will work most directly with the educational efforts in Washington, DC.

San Francisco Needs Assessment Supplement
Susan Shea introduced *Michael DeMayo* from Harder +Company Community Research for an update on last year's work. Michael explained the rationale for doing a new chapter or an addendum to the Needs Assessment. The report he distributed is intended to replace the chapter in last year's report covering the Client Survey summary. This new report contains updated data, gathered from a second wave of interviews concentrated among population groups that were under-sampled previously. Michael's oral presentation was a synopsis of the written report passed out to Council members. A total of 315 additional surveys were conducted. After re-running all the data with the larger sampling numbers, there weren't significant changes in

the statistical distributions. Ten health service categories are included in the Needs Assessment. In summary, the three categories with highest "unmet need" were the same as last year: Home Health Care, Housing Assistance and Dental Care. The higher sampling of homeless people revealed again how much HIV disease had complicated their situations. For about half of the homeless people surveyed, being without a home was considered to be the result of having HIV or AIDS. Michael received a question about the attempt to sample the population of youth (18 years or less) with HIV. Only one such interview took place, and it was reported as very challenging trying to find this client population. Additional data analysis of unmet need will be done in the future, including by age category, separating out those 24 years old and under.

HIV Health Services of DPH Report

Laura Thomas passed around the latest issue of HRSA's newsletter. She announced that the Ryan White CARE Act Reauthorization legislation before Congress is now identified by its number, S-2311, or as the Kennedy-Jeffords Bill. She said neither of the California Senators was among the 20 co-sponsors to date. In the House of Representatives, Rep. Coburn has introduced an independent version of the Reauthorization bill, with many additional legislative requirements. One is a requirement to use the reported cases of HIV as the basis for distributing funds, rather than AIDS. Since California is not a state that has HIV reporting at this time, we may end up at a disadvantage in allocations. Rep. Pelosi is very active also on these matters. Laura also reported on some grant applications.

Treatment on Demand Heroin Committee Presentation

Jennifer Friedenbach is from the Coalition on Homelessness and a member of the Treatment on Demand Planning Council. That Council has been examining the Heroin epidemic and many issues related to the use of heroin in San Francisco. A Draft Document was presented and input was sought from members of the HIV Health Services Planning Council. The document contains numerous recommendations. Jennifer highlighted Overdose Prevention, and added further information on accessibility to detox and alternative treatments. *Norma Hotaling* is from the SAGE Project and also a member of the Treatment on Demand Planning Council. She presented material on Soft Tissue Infection (STI) from needle use and on the reality that Hepatitis C has become a major health concern. Hepatitis C appears to be more easily transmitted than is HIV in the context of needle usage. She called for incorporating many lessons learned from the fight against HIV and AIDS in this new round of struggle involving Hepatitis infection. Discussion followed on the topics of harm reduction, on advocacy concerning the length of time allowed in residential detox treatment (if paid for by the State), as well as treatment options for Hepatitis C infection. *Gene London* reported that acupuncture and alternative treatments are proving very successful in treating co-infection of HIV and HCV (Hepatitis C). There is a great deal of activity on HCV prevention, education, testing, screening and research—particularly by a California State Hepatitis C Task Force. Many other ideas were expressed about treatment options for co-infected patients (HIV and HCV).

SFDPH Epidemiology Report

Willie McFarland made a presentation entitled "Status of the HIV/AIDS Endemic in the HAART Era: San Francisco 1995-2000." The purpose was to characterize who is now living with AIDS, living with HIV, and newly infected with HIV in order to present an accurate current snapshot of the HIV crisis. The presentation gave information on how the era of new treatments has impacted the epidemiology of HIV. The number of new infections has been remaining approximately the same each year. The peak of HIV infection was in the early 1980s, and the period from infection to AIDS diagnosis was then calculated to be about 10 years, therefore the peak of AIDS incidence figures was in the early 1990s. He noted that the decline in AIDS incidence started in 1993, even before the time period identified by HAART. The number of new diagnoses is now leveling off at close to 500 per year. Next, he noted deaths from AIDS reaching a plateau in the early 90s, followed by a drop in deaths from 1995 on. This corresponds with an increase in use of HAART, which went up sharply in '95. At least four to five years of survival time have been added as a result of using HAART. Whites have achieved these gains before African Americans and Latinos. There are now greater numbers of San Francisco residents living with AIDS than at any prior point in the epidemic. Of the people with HIV, about half of them have an AIDS diagnosis and half do not. Therefore, the best way to get an estimate of the

overall numbers of HIV infected people at this point in time is to double the numbers of diagnosed AIDS cases. That formula leads health planners to an estimate of 17,196 people living with HIV or AIDS in San Francisco, up from the 1997 figure of 15,000. The epidemic here is overwhelmingly male, with 94%. He used maps of San Francisco to portray the distribution of cases by census tract for each population group and transmission category. Finally, he analyzed the statistics for HIV seroconversion by race/ethnicity, gender and transmission category. The highest rates of conversion now are for men who have sex with men and use injection drugs, for men age 25 to 35, and for Latinos using anonymous testing sites. He presented the following conclusions: HIV/AIDS is endemic in San Francisco. That is, a balance exists among the factors of prevention, treatment, survival, behavior, immigration and other social/demographic factors. HIV/AIDS will persist in San Francisco's severely affected communities for some time to come. This dynamic balance may not last because there are indicators of increasing risk. The studies show definite benefits from treatment. On the individual level, survival time continues to improve. On the community level, treatment probably suppresses transmission. Brief questions and comments followed the presentation.

Steering Committee Report

SJ announced his resignation from the Council and as one of its co-chairs. He thanked a number of people for their assistance during his period of service on the Council. *SS* asked for nominations of people to replace Siddiq as Council co-chair and serve in that capacity until the next regularly scheduled elections. Susan announced that nominations would be open until the next monthly Council meeting (May 22nd). Nominated immediately were Stephan Oxendine and Laura Carcagno Guzman. Both nominations were seconded. Additional nominees are welcome and may be forwarded to co-chair Eric Whitney. Co-chair terms of office are one year, starting in September. On a separate topic, Susan passed around a copy of the Council Support budget.

Housing Committee Report

Ali Riker, Chair of the Housing Sub Committee, introduced the issue of a change in allocated funds between different sub-categories. Such a change requires a vote by the full Council, in order to move money from one category in the prioritization plan to another. Margo Antonetty talked about the specific housing program and how the provider had decided not to renew the contract. The services that were provided to some clients at an old location, the Ambassador Hotel, are not feasible any longer at the current location, Franciscan Towers. It's also not feasible to move these services to another provider. The recommendations from DPH Housing Services include keeping subsidies for all the clients and maintaining a small contract for administration of the current clients' subsidies. The other services provided—mainly Case Management—are no longer needed. Clients will have access to money management through LSS. Some other support services are available also. In the current year's budget there would be a savings or "unfunds" situation. It is recommended that this money be used for Eviction Prevention during this fiscal year and as a contribution toward a transitional housing project next fiscal year. The move between sub-categories is from Case Management to Eviction Prevention. A motion was put forward in order to make this transfer between categories. The Franciscan Towers is for low-income people, specifically those receiving General Assistance. That is the program design that was approved by the Council. Some members spoke against the concept of not refilling the units that become vacant and/or spoke in favor of more flexible criteria for approving the subsidy clients. Everyone agreed with the desire to not lose any housing subsidy slots (13 in the original design of this program). A friendly amendment was added having the intent of exploring the option of using more flexible criteria to fill current/future openings at Franciscan Towers. A roll call vote was taken. The motion passed 26 to 0, with 1 abstention (see Roll Call Sheet, Column 2). *Gary Harrell* asked the Housing Sub Committee about its vote in favor of closing the Housing Wait List and expressed dissatisfaction with the 3:00 PM start time of Housing sub committee meetings. *AR* explained that a meeting has been scheduled in order to obtain public input about the proposed changes in the Housing Wait List. The vote had been taken as a straw pole among seven Council members present at the meeting. Other people are welcome to attend the Housing Sub Committee meetings, including service providers. But, they do not take part when votes come up. The meeting time will be re-examined.

PWA Caucus Report

Veronika Cauley referred members to the report contained in the packet of written materials. She felt there wasn't anything substantive to add.

Membership Committee Report

Laura Guzman said that there were some challenges for the committees about finding the right time for their meetings and otherwise attracting attendees. She reminded everyone about the need to make a committee selection and at least try for regular attendance. Toward that end, she passed around forms which members are invited to fill out and indicate their preference in committee work. Then, she brought up two nominees for a vote by the full council in order to send these nominations to the Mayor for possible appointment to the Council. The Membership Committee had recommended both of these candidates. The Council's vote was then conducted by consensus, and there appeared to be unanimous agreement on both of the nominees. Additionally, Hazel Betsey has asked for a two-month leave of absence from the Council.

VIII. New Business

Eric Whitney said that stipends were still available to Council members who are people living with AIDS. He has the forms at this meeting for anyone who would like.

IX. Adjourn

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

May 22, 2000

AGENDA

for 5/22/00
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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 4/24 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SFDPH, Harm Reduction—Presentation by Josh Bamberger*	**4:55 PM**
	• *SFDPH, Strategic Planning—Presentation by Tangerine Brigham*	**5:05 PM**
	• *Implementation & Evaluation Committee*	**5:25 PM**
	Un-funds Working Group—Update	
	Client Satisfaction Survey Working Group	
	Prioritization 2001-02—VOTE	
	• *Steering Committee*	**5:45 PM**
	Reauthorization Letter	
	5-year Strategic Planning	
	Closing of Co-chair nominations	
	Election of new Planning Council Co-chair	
Break		**6:00 PM**
	• *Resistance Testing—Presentation by Michelle Roland, MD; Ben Cheng & Anne Donnelly of Project Inform*	**6:15 PM**
	• *Membership Committee*	**7:00 PM**
	Clarification of Committee attendance	
	New Member Nominations—VOTE	
	• *PWA Caucus*	**7:10 PM**
	Tenderloin Community Forum	
	• *Housing Committee*	**7:15 PM**
	Housing Wait List Community Forum—Update	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

Upcoming meetings:

Day	Date	Type	Location	Time
Mon	6/5	5-year Planning Committee	25 Van Ness, Room 330B	3:00 – 5:00 PM
Mon	6/5	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Wed	6/7	Housing Committee	25 Van Ness, Room 330A	3:00 – 5:00 PM
Wed	6/7	PWA Caucus	25 Van Ness, Room 330A	5:30 – 7:30 PM
Thurs	6/8	Membership Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Mon	6/12	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	6/19	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Mon	6/26	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

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An Urgent Message from Project Inform and the HIV Advocacy Network of the San Francisco AIDS Foundation

24 Co-Sponsors of Senate Ryan White CARE Act Reauthorization Bill

Call Senators Boxer and Feinstein Immediately!

Urge them to Join this Growing List of Co-Sponsors

As you've read in previous Alerts, reauthorization of the Ryan White CARE Act cleared its first hurdle when S. 2311 was approved unanimously by the Senate Health, Education, Labor, and Pensions Committee. The Ryan White CARE Act provides health care, treatment, and support services for people living with HIV/AIDS. The CARE Act is due to expire on September 30, 2000 and needs to be "reauthorized", or renewed, by Congress and signed by the President.

The Senate reauthorization bill -- S. 2311-- is authored by Senators Kennedy (D-Massachusetts) and Jeffords (R-Vermont) and leaves much of the current bill language intact. It also includes some improvements, such as the development of minimum standards to ensure high quality care for all CARE act recipients. CARE reauthorization legislation has not yet been introduced in the House of Representatives.

Currently, 24 of the 100 U.S. Senators have signed on as cosponsors of S. 2311. However, California Senators Dianne Feinstein and Barbara Boxer have not yet agreed to cosponsor the bill. They have both been strong supporters of the CARE Act, and are leaders in the nation's response to HIV/AIDS. It is very important that they co-sponsor this legislation and demonstrate that California needs swift reauthorization of this lifesaving bill. There are less than 50 working days left for Congress to act on this bill before adjourning for the November elections. A large number of cosponsors would help encourage Senate Majority Leader Trent Lott to bring the issue up for debate and a vote by the full U.S. Senate in May or June.

Action needed:

Call Senators Feinstein and Boxer's office. Politely tell whoever answers the phone:

"I am calling to urge Senator Feinstein/Boxer to co-sponsor S. 2311 immediately. This bill would reauthorize the Ryan White CARE Act, which provides critical health care and treatment services for people living with HIV/AIDS. I appreciate Senator Feinstein/Boxer's leadership on HIV issues in the past. We need her leadership now."

Don't forget to leave a personal message --if you or someone you care about relies on services provided through the CARE Act, let their offices know.

Contact information:

Senator Dianne Feinstein 202/224-3841

Senator Barbara Boxer 202/224-3553

Please spread the word and share this e-mail alert with others that would be willing to make similar calls. With our strong grassroots efforts, we can make a difference! For further information, please contact the San Francisco AIDS Foundation at 415/487-3080 or Project Inform at 415/558-8669 x224.

WHEREAS, the San Francisco Department of Public Health seeks to reduce adverse health effects to individuals, to individuals' families and to the broader community through legal and compassionate interventions; and

WHEREAS, the Harm Reduction model of health care, offers multiple approaches to assist clients to move toward better health; and

WHEREAS, the Harm Reduction model attempts to reach clients in the clients' environments to assist the clients in making choices leading toward better health; and,

WHEREAS, deaths in the City and County of San Francisco due to injection drug overdoses reached 180 in 1999- the third leading cause of lost years of life; and,

WHEREAS, 95% of injection drug users are infected with Hepatitis C and 16 % are infected with HIV; and

WHEREAS, 90% of new cases of HIV in San Francisco are among men who have sex with men; and

WHEREAS, soft tissue infection is the leading diagnosis at San Francisco General Hospital, leading to 1400 inpatient admissions in 1999 costing $18,000,000, seventy percent of which patients were uninsured; and

WHEREAS, needle exchange, a Harm Reduction program, has proven to decrease further HIV and Hepatitis C infections by providing clients with clean needles with which to inject; and,

WHEREAS, outreach services encourage hidden populations to seek care for health and substance use concerns; and,

WHEREAS, practicing safer sex reduces the likelihood of transmission of sexually transmitted diseases including HIV; and,

WHEREAS, abstinence based programs are successful for some, but not all individuals; and

WHEREAS, recovery from substance use, practicing safer sex and improving health status takes place in an incremental manner be it

RESOLVED, that all agencies contracting with the San Francisco Department of Public Health shall address in the contract how Harm Reduction treatment options are provided by the agency; and be it

FURTHER RESOLVED, that each division within the Department of Public Health shall determine the manner of Harm Reduction appropriate for the specific division and shall include those guidelines in all programs.

FOR STAFF USE ONLY. Date: ___/___/___ Agency: _____ ☐PC ☐CM Staff-assisted? ☐ Yes

HIV Health Services Planning Council
Client Satisfaction Survey

Directions

Please fill out the following survey about your satisfaction with services you have received from this agency. Fill in the bubbles next to the answer you pick for each question, or write in your answer if there is a space or box provided. Your answers will be anonymous. No one will be able to tell which answers are yours. The information you provide will be used to improve services in San Francisco.

Please Read

Please **DO NOT** fill out this survey if:

- You have already filled out this particular survey at this agency **OR**
- You have been receiving services at this agency for less than one month

Please answer the following questions about yourself.

1. What is your gender?

☐Male ☐Male to Female Transgender
☐Female ☐Female to Male Transgender
☐Intersex ☐Other: _____

2. What is your age? _____

3. What is your racial/ethnic background? (mark all that apply)

☐Asian/Pacific Islander ☐White/European-American
☐Black/African American ☐Don't know
☐Latino/a ☐Other: _____
☐Native American

What language are you most comfortable speaking? (mark only one)

☐English ☐Spanish ☐Other: _____

5. What is your total *personal* income per month, adding all sources together?

☐$0 (No Income) ☐$901-$1200/month
☐$1-$300/month ☐$1201 or more/month
☐$301-$600/month ☐Don't know
☐$601-$900/month

6. Please fill in the appropriate bubble regarding your HIV status.

☐I am HIV positive, but I do not have an AIDS diagnosis.
☐I am HIV positive, and I have an AIDS diagnosis.
☐I do not have HIV or AIDS.

7. Where do you currently live? (mark only one)

☐Street, park, car or abandoned building ☐Halfway house or drug/alcohol program
☐Shelter ☐Hospital/institution
☐Emergency housing, not shelter ☐Single room occupancy (SRO) hotel room
☐Living or crashing with someone and not paying rent ☐Renting or own house, apartment or flat
☐Jail/incarcerated
☐Other: _____

Please answer the following questions about the support staff – the people at the front desk and those who answer the phone.

8. The support staff have a good personal manner (they are friendly, respectful, nonjudgmental, etc.):

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

9. The support staff explain things to me in a way that I can understand:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

Please answer the following questions about the care staff – the people who give you your care at this agency, including doctors, nurses, case managers, social workers, treatment advocates, peer advocates, and anyone else who is involved in decisions about your care or treatment.

10. The care staff have a good personal manner (they are friendly, respectful, nonjudgmental, etc.):

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

11. The care staff are available to help me when I have questions or need assistance:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

12. A care staff member who speaks my language is available to talk with me when I have questions or need assistance:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

13. The care staff explain things to me in a way that I can understand:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

14. I have confidence in the abilities of the care staff:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

Please answer the following questions about your general satisfaction with the services you receive from this agency.

15. I am able to get services when I need them:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

16. I feel safe at the agency site:

☐All the time ☐Most times ☐Sometimes ☐Rarely or never

17. Overall, the services I have received from this agency are:

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

Please turn the page over to finish survey

Please read each of the following questions about whether the staff understand the needs of different groups. Answer all that apply to you.

If you are AGE 24 OR YOUNGER, please answer the following question:

18a. The staff understand the needs of young people:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are AGE 50 OR OLDER, please answer the following question:

18b. The staff understand the needs of older adults:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are FEMALE, please answer the following question:

18c. The staff understand the needs of women:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are GAY, LESBIAN, OR BISEXUAL, please answer the following question:

18d. The staff understand the needs of gay, lesbian, and bisexual individuals:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are HETEROSEXUAL, please answer the following question:

18e. The staff understand the needs of heterosexual individuals:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are a PERSON OF COLOR, please answer the following question:

18f. The staff understand the needs of people of my ethnic/cultural group:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

If you are TRANSGENDER, please answer the following question:

18g. The staff understand the needs of transgender individuals:

- ☐All of the time
- ☐Sometimes
- ☐Most times
- ☐Rarely or never

19. If we were going to make changes to improve services, what changes would you like to see us make? (please print neatly inside the box below)

Thank you very much! Please put your survey in the envelope, seal it, and sign across the sealed flap. (You do not have to sign your own name.)

HIV Health Services Planning Council
Minutes, May 22, 2000

DRAFT

I. Call To Order

EW gave call to order. 4:30 PM

II. Roll Call

Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda

EW introduced one change, to move the Housing report as first item. Agenda approved with change.

IV. Review and Approval of Minutes (VOTE)

LCG asked that in the Membership Minutes it should read as "Women POC" as an inclusive phrase. Motioned for the approval of 4/24/00 Council Minutes was made. Minutes approved.

V. General Announcements

VC commented that she attended the Candlelight Memorial and felt that the word "Transgender" needed to be stated and included not assumed to be inclusive of everyone.

VI. Public Comments

Michael Petrelis, Project Director, AIDS-STATISTICS.COM accused the Planning Council of taking ads from Project Inform and SFAF encouraging people to lobby for Ryan White funding.

VII. Reports

Housing Report

- *AL* introduced *Mark Trout*, SFAF, who gave historical background on the SFAF Housing Waiting List. He reported on a recent meeting regarding the decision of SFAF to institute the following changes in the Housing Wait List: (1) a comprehensive clean-up and outreach of persons on the list and those persons that were eligible, (2) suspend new persons on the list, (3) do selective list openings as space becomes available. He reports that these changes were needed to keep the list viable, manageable and keep the length of time on the list to a minimum. There was discussion and questions about the changes. *LCG* expressed concern about outreach to the homeless, as they are most likely not to have a fixed address. She advised that extensive street outreach was the only true outreach particularly to this population.

Harm Reduction Presentation

- *Josh Bamburger*, Action Point presented an early draft of a Harm Reduction policy and resolution. He requested feedback from Council members on crafting specific language to then move this forward to the Health Department for consideration. *EW* asked that members with specific language to consider for the Harm Reduction piece to send it to him to give to *JB*. *LCG* agreed with the presentation but felt that it needed more statistics to include community-based agencies and to expand to mental health considerations. *SJ* reported that the Sheriff's Dept. was instituting similar changes.

Strategic Planning Presentation

- *Tangerine Brigham*, DPH presented on the Strategic Planning Initiative. She reported on the need for services to be revelant, which the communities needs are in a Social as well as a Public Health model. *VC* reported that there was an oversight regarding the lack of trangender concerns in the report. *EW* informed *TB* of the PWAC meetings and its co-chairs. *TB* requested feedback and would make recommendations in September.

Implementation & Evaluation Report

- *EW* reported in the Client Satisfaction Survey Working Group. *LCG* asked if the survey would be done in Spanish to which *EW* replied that it was being translated into Spanish. *JK* asked if this survey

would supersede agencies' Client Satisfaction Surveys. *EW* replied that some places would prefer to do their own surveys.

- *GG* reported on the Unfunds Working Group. He encouraged members to attend the working group to offer feedback at the last meeting on 6/5/00
- **Prioritization 2000-2002 – VOTE**

GG gave background to work on Prioritization. *EW* commended members on work. *MS* commented on item #15 under Health Care that the issue of HIV+ gay men and sexuality discussion be included. There was some discussion on this point. A member called for point of process. *GG* motioned for a roll call vote. Prioritization 2000-2002 passed unanimous.

Steering Committee

- *EW* passed out Reauthorization letter. He spoke about the Five-Year Planning Committee work. *EW* asked for nomination for co-chair as *SJ* was resigning. *LCG* withdrew her name from consideration. No other name came forward. *SO* reminded for consideration. *JC* suggested that *SO* be carried as co-chair as there were no other names to consider.
- The Updated HIV Resource Guide was passed out to Council members.

Resistance Testing Presentation

- *Ben Cheng*, Project Inform presented the background about Resistance Testing and its importance. *Michelle Roland*, MD presented the Updated IAS Recommendation Guidelines and her clinical experience with Resistance Testing. *Anne Donnelley*, Project Inform presented funding for Resistance Testing and quality control issues.

Membership Committee

- *LCG* asked that Council members consider attending committee meetings to support them. She forwarded *Cecelia Chung* for membership. *CC* was voted in with no opposition.

PWA Caucus

- *JM* announced that there would be a Community Forum in the Tenderloin at TARC on 6/27/00. He reports that there would be a need to strategize on outreach efforts in the area.

VIII. New Business

No new business was reported.

IX. Adjourn

7:30 PM

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

June 26, 2000

AGENDA

DOCUMENTS DEPT.

JUN 22 2000

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I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 5/22 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SFDPH HIV Health Services* Reauthorization Update	**4:55 PM**
	• *Presentation—Integrated Service Provider—WIDS*	**5:10 PM**
	• *Implementation & Evaluation Committee* Un-funds Policy & Procedures—**VOTE**	**5:25 PM**
Break		**6:00 PM**
	• *Implementation & Evaluation Committee, Cont'd (if necessary)* Un-funds Allocations for Roll-over Dollars—**VOTE**	**6:15 PM**
	• *PWA Caucus* Tenderloin Community Forum	**6:45 PM**
	• *Membership Committee* Clarification of Committee attendance Committee Assignments	**6:55 PM**
	• *Housing Committee* Reinvisioning Housing Report HOPWA Loan Committee (Demographics in RCFCIs)	**7:05 PM**
	• *Steering Committee* 5-year Plan Working Group 6-month Work Plans for Committees Clarification of Public Comment	**7:15 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

Upcoming meetings:

Day	Date	Type	Location	Time
Mon	7/3	5-year Plan Working Group	25 Van Ness, Room 330B	3:00 – 5:00 PM
Wed	7/5	Housing Committee	25 Van Ness, Room 330B	3:00 – 5:00 PM
Wed	7/5	PWA Caucus	25 Van Ness, Room 330B	5:30 – 7:30 PM
Thurs	7/6	Membership Committee	25 Van Ness, Room 330B	5:00 – 7:00 PM
Mon	7/10	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	7/17	Implementation & Evaluation Committee	25 Van Ness, Room 330B	5:00 – 7:00 PM
Mon	7/24	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Tues	7/25	5-year Plan Working Group	25 Van Ness, Room 330B	3:00 – 5:00 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. Accessible MUNI lines serving these locations are. #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station.

Minutes of meetings are tentative until formally approved by the Council.

TO: HIV Health Services Planning Council (HHSPC)

FROM: Implementation & Evaluation Committee
UNFUNDS Working Group

DATE: June 21, 2000

RE: **Proposed UNFUNDS Policy and Procedure**

The HHSPC Implementation and Evaluation (I & E) Committee will be submitting proposals related to the use of UNFUNDS for Council approval at its June 26, 2000 meeting. Background information about the definition and use of UNFUNDS, and details of the I & E Committee's proposals which would become the Council's UNFUNDS Policy and Procedure are outlined below. The proposals are:

1. **Establish three different categories for the use of UNFUNDS:**

    1) Program Infrastructure Support
    2) Program Enhancements and Stabilization
    3) System Development and Evaluation

2. **Decide on which Programs should be eligible for Program Infrastructure Support**

3. **Adopt I & E's recommended timeline and process for disposition of FY2000-01 UNFUNDS.**

4. **Adopt I & E's recommended timeline and process for the annual prioritization and allocation of UNFUNDS, beginning in FY2001.**

BACKGROUND INFORMATION

The strategy for prioritizing and allocating HIV health services dollars is built on the assumption that DPH's HIV Health Services Branch (HHS) and its contractors will strive to leave as little money on the table as possible at the end of each fiscal year. However, there is always the possibility that some funds will remain unspent. These are referred to as "UNFUNDS.

In the past, the Council has not had in place a policy and procedure for dealing efficiently with unspent funds. Instead of a sound and consistent process which Council members have agreed upon, a variety of approaches to dealing with UNFUNDS have been used, often consuming a lot of Council effort and producing only mixed results.

To address this issue, in Spring 2000 the I & E Committee's UNFUNDS Working Group held a series of meetings and discussions with consumers, providers, and HHS to develop a process for distributing UNFUNDS as effectively and efficiently as possible. The proposals which I & E is submitting for Council approval are the result of these meetings.

DEFINITION OF UNFUNDS

There are two types of UNFUNDS that potentially become available at different times each program year:

Rollover UNFUNDS:

Definition: Funds that become available when contractors are not able to use the full amount of their contracted dollars during the prior year.

Amount: Dollar amounts are unpredictable but in the past have ranged from 500-1000K.

Can be used for: These monies are good for one-time projects only and must be used for projects that HRSA will allow.

When available: Knowledge of this fund amount becomes available in June of each year. HHS makes a request for use of rollover funds to HRSA in June and usually receives HRSA's response in late summer or early fall.

Fall UNFUNDS:

Definition: Funds that do not become incorporated into contracts during contract negotiation, or become available as the result of cancelled contracts.

Amount: Dollar amounts are unpredictable but in the past have ranged from 300-500K.

Can be used for: May be used for ongoing projects or one-time projects, depending on whether the unallocated projects are expected to be operational in future years.

When available: This dollar amount is usually known around November of each year.

PROPOSED UNFUNDS POLICY & PROCEDURE

1. Establish three different categories for the use of UNFUNDS:

Category 1: Program Infrastructure Support
For many years, the Council has been struggling with how to provide cost of living increases to providers (contractors) in the CARE network. Contractors have not had any contract increase in the last several years, even though their "cost of doing business" (CODB) has increased. The Council and HHS have not been able to increase contract amounts at all because our grant award amount has decreased each year. Many Council members and HHS staff have thus worked to develop an appropriate plan for using UNFUNDS as CODB increases that is fair to all contractors, simple for HHS to carry out, and assures a fair distribution system.

After lengthy discussions on this issue, I & E recommends that the Council designate each year an agreed-upon proportion of Fall UNFUNDS for Program Infrastructure Support, and distribute these funds to contractors as COBD increases in the following manner:

- To address the chronically under-funded infrastructure needs of service providers, a proportional share of Fall UNFUNDS (based on the original dollar amount of the exhibit of the contractor) would be allocated to all contractors who meet the performance criteria (see below for criteria). The amount to be spent on this category will be decided by a Council vote each fall.

- These funds would be used for one-time purchases (including, but not limited to, equipment) related to the contracted services.

- In order streamline this process and require the least number of contract modifications, HHS will distribute funds in the most efficient fashion possible (e.g., make an award to one contractor, who would then subcontract monies to all other contractors for one-time purchases). The Provider who receives this contract will notify the sub-contractors eligible to receive an award, and require a very short turnaround time for accepting the offer. Contractors would be asked to identify how they would use the UNFUNDS, and why the additional funding is necessary for the contracted service. If an agency does not respond, refuses the money, or proposes to do something unrelated or unnecessary, or is inconsistent with Federal, State or County regulations, that share would be redistributed to others.

This method assures that Fall UNFUNDS address a real need, are invested in the infrastructure necessary to provide prioritized services, and use a method that is fair and not cumbersome to the council or HHS.

Contractors not eligible for Program Infrastructure Support would include:

- Programs with monitoring reports that have "improvement needed" or "unacceptable" program ratings from the previous contract year;
- Programs with less than 90% UOS delivered overall in the previous contract year;
- Programs in their first year of funding.

"Note: These policies and procedures apply to San Francisco City and County UNFUNDS. Marin and San Mateo Counties determine the use of any UNFUNDS from their CARE allocations through their respective local planning processes."

Category 2: Program Enhancements and Stabilization
This category would include:

a) Amount needed each year to cover the proposed cut per year in our grant by HRSA. (still an unknown until reauthorization of Ryan White Care Act is completed.)

b) Requests for UNFUNDS generated by the yearly prioritization process.

c) Vouchers for transportation, household goods, and food, which we must invest in each year but to a different level each year depending on use, etc.

Category 3: System Development and Evaluation
This category would include:

a) Projects needed to continue to evaluate our system of care (e.g. Client satisfaction Survey)

b) Projects to develop our system of care (e.g. 5-Year Plan).

2. Decide on which Programs should be eligible for Program Infrastructure Support
Please read the email sent with pros and cons of this vote.

3. Adopt I & E's recommended timeline and process for disposition of FY2000-01 UNFUNDS:

Because we have just completed drafting the proposed UNFUNDS policy and procedure, the timeline for this year will be different than for the years ahead. The I & E Committee recommends the following timeline for 2000-2001:

June 19, 2000:
Requests for Rollover UNFUNDS for Program Enhancements and Stabilization, and System Development and Evaluation will be accepted by the I & E committee and forwarded to the Council for a vote at the June 26th Council meeting. Requests will be forwarded to the Council with a recommendation from I & E about the order and priority of funding.

June/July 2000:
HHS informs Council of Rollover UNFUNDS amount. HHS makes request to HRSA for use of Rollover UNFUNDS for projects sent to HHS from the Council's vote in June in the order prioritized by the Council.

September 2000:
Notification from HRSA on acceptance of Rollover UNFUNDS request. Any projects rejected by HRSA will be returned to the I & E committee to evaluate whether funds for the projects should be sought from the Fall UNFUNDS.

October-November 2000:
HHS notifies Council of Fall UNFUNDS amount. I & E committee reviews amount and any requests for UNFUNDS from the Program Enhancements and Stabilization category and the System Development and Evaluation category (this request should be very small if anything at all because these requests would have been covered by Rollover UNFUNDS). Fall UNFUNDS are then distributed to the Contractors using the formula described above under the Program Infrastructure Support category (see #1 above.)

4. Adopt I & E's recommended timeline and process for the annual prioritization and allocation of UNFUNDS, beginning in FY2001:

Winter and Spring of each year:
I& E committee will begin to collect Rollover UNFUNDS requests from the Prioritization process (which includes consumer and public input;) the co-chairs of the committee, and any of the subcommittees of the Council. The I & E Committee will prioritize and assign the requests to the appropriate category for UNFUNDS requests. The Rollover UNFUNDS will usually be used for Program Enhancements and Stabilization category, and the System Development and Evaluation category. This list will be prioritized by I & E and sent to the Council for a vote in June of each year.

June of each year:
HHS informs the Council and I & E Committee of the Rollover UNFUNDS amount. If the amount of Rollover UNFUNDS is greater than the amount requested for the projects voted for by the Council in June then the remaining amount is given to the Program Infrastructure and Support category.

August/September of each year:
HHS is notified by HRSA about request for Rollover UNFNDS, and the I & E Committee makes recommendations about projects not funded by Rollover UNFUNDS to be considered for Fall UNFUNDS. The I & E Committee also includes any requests for Fall UNFUNDS from the Program Enhancement and Stabilization category or System Development and Evaluation category. The bulk of Fall UNFUNDS each year will be prioritized to the Program Infrastructure Support category for use by the contractors after an evaluation of the unfunded projects leftover from prioritization of the Spring has occurred. This list is voted on by the Council at the October Council meeting and is then forwarded to HHS.

October of each year:
HHS informs the I & E Committee and the Council about the Fall UNFUNDS amount. HHS will then implement the Fall UNFUNDS prioritized from the October Council meeting.

Rollover UNFUNDS Requests
Recommendations from I&E For Rollover UNFUNDS 2000

Category	Description of Project	$ Amount Requested	I & E Ranking of Request
Program Enhancement: Health Care	4.Maximize use of Medi-Cal for home health care (including use of the Medi-Cal waiver program) 5. Analyze the utilization of and need for attendant care as compared to the need for practical support services. 8. Increase access to attendant care in clients' homes and residences (including SROs)	25 K for Task force on case management, peer and treatment advocacy and practical support and attendant care will be initiated this summer as part of I&E's evaluation phase of its work plans for the year.	1
Program Enhancement: Other Support Services	3. Evaluate process of how and to whom emergency financial assistance needs to be offered. 6. Better coordination of case managers for each client (for clients with more than one case manager) through: A. Defining and applying the definition of "case manager B. Surveying current programs to determine the number and function of case managers funded outside of the Case Management category C. Conducting an assessment to determine: how many case managers an individual client has; whether the use of multiple case managers is appropriate (contractually driven, need based, or programmatically mandated); which programs mandate case management in	(See above) Recommend a short-term task force to evaluate whether emergency financial assistance should continue as a stand-alone service or should these dollars be integrated into Case management services. These recommendations will be included in above Task Force.	1

	order for clients to receive other services; and how case managers are trained and what are the qualifications needed to provide case management D. Investigating the feasibility of clients designating a primary case manager through surveying clients, case managers, and program administrators. 7. Treatment advocates, peer advocates, and case managers must be better integrated with the primary care providers and medical care team. 10. Training for peer advocates on standards of practice and other service-related issues (e.g. boundaries, preventing burnout, etc.) 13. Develop standards of practice for treatment and peer advocates within the next year. 19. Define coordination of case management		
Program Enhancement: Housing	19.Increase legal advocacy for eviction prevention. Make emergency housing and direct emergency financial assistance funds, including eviction prevention funds, available at legal advocacy sites.	27 k for legal advocacy	2
Program Enhancement: Adherence Assistance	Food Vouchers Household Vouchers	100 k Food 100 k Household 2/3 rds to Food 1/3 rd to Household Goods up to above maximums	3

Program Enhancement: Housing	19.Increase legal advocacy for eviction prevention. Make emergency housing and direct emergency financial assistance funds, including eviction prevention funds, available at legal advocacy sites.	213 k for Eviction Prevention Project	4
Program Enhancement: Health Care Substance Use	9. Better integrate home health and medical care with substance use providers, especially residential substance use facilities, to enable clients to stay in residential facilities.	1-2 K for facilitatior to arrange and facilitate 2-3 meetings among all these providers to assess strategies to address this problem. This task force will then forward recommendations to I&E for prioritization 2002-04.	5
Program Enhancement: Housing	14.Support harm reduction model housing training for residential staff working with active users. (Housing committee suggests we change language to educating staff since no money available for new housing at this time.)	10 k UNFUNDS Request for harm reduction education specific to non residential non-licensed facilities like the hotels in the tenderloin	6
Program Infrastructure Support:	Additional monies for Home care services for licensed residential facilities due to cuts in State RALF funding.	$ 56,803	7
Program Infrastructure Support:	Pay increased bank fees for Money Management service	$ 8,550 for 9 months	8
System Development and Evaluation:	Cost Caps Task Force	10 K	9

Program Enhancement: Substance Use	Treatment on Demand Council is proposing to the Care Council that we match 200k for better substance use services for clients with subs use issues who are also HIV +	200 k	Treatment on Demand Council does not have matching funds so this has been pulled off the table.
Program Enhancement *: Housing	8.Educate/Provide emergency hotel staff about/with housing programs and available support services, such as crisis intervention and practical support and that it be multicultural with multiple translations available.	5 K	Pulled from UNFUNDS request by Housing Committee

* Please see UNFUNDS P & P for definitions of these UNFUNDS Categories

HIV Health Services Planning Council
Implementation and Evaluation Committee

May Report

Meeting Date/Time:	Monday, May 15, 2000, 5:00 – 7:00 PM
Members Present:	Gene Gowdey and Steve Oxendine, I&EC Co-Chairs, Susan Shea, Council Co-Chair, Bob Teague, Catehrine Geanuracos, Gene London, Margot Antonetty, DPH-Housing Services
Others Present:	Russ Zellers, DPH - HIV Health Services, Jim Illig, HIV Contractors' Assoc., Celinda Cantu, HHS, George Simmons, CCASF, Nan O'Connor, Center for Special Problems
Next Meeting:	Monday, June 05, 2000 25 Van Ness, Room 330-A, 5:00 PM – 7:00 PM

Call to Order
GG gave a call to order. Introductions of participants were made.

Introductions of New Attendees
Participants introduced themselves.

Review and Discussion of Prioritization Plan
SS presented the final draft of the Prioritization line items. *GG* reported that the Prioritization packet was planned for Council vote on May 22nd. *SS* will update the Unfunds Subcommittee on June 5th.

Review by Subsection
Under Health Care, item #16 there was discussion about the need for clarification of how Title F dollars could be more effectively utilized. This section was adopted.
Under Housing, item #23 after some discussion *SS* proposed a compromise motion that this year Unfunds would be used to other this item, then next year look into other funding sources to cover the need. This section was adopted with suggested changes in item #23.
Under Mental Health, there were no questions. This section was adopted.
Under Substance Use, there were no questions. This section was adopted.
Under Other Support Services, item #3 was moved to integrating into case management. It would be reviewed this summer in the task force for Other Support Services. Items #6 and #4 were integrated into case management. This section was adopted.

Discussion of Additional Housing Considerations
The Housing Committee has introduced an Unfunds request for $227,000 of new on-going funds. In addition to the request, Housing wished to add three new Housing priorities. There was some discussion regarding requests from the Housing Committee versus other committees not meeting at regular intervals. It was felt that there was indeed an established need in either case and would be considered by the Unfunds Committee.

Spring Unfunds Request
SS presented the Spring Unfunds request document. The Housing request for $227k was added. . RZ reported that there was information about HOPWA one-time only home care dollars. It was suggested that the AIDS Office bring the information to the Unfunds meeting. LT reported that Treatment On Demand depends on the Mayors' Office and the Board of Supervisors' fiscal prioritizations for TOD dollars. The hope was that the CARE Council would match the funding for HIV-infected consumers. There were concerns expressed regarding diminishing CARE dollars to match this request.

Old or New Business
SS introduced Draft 3 of the Proposal for Unfunds. This would be revised. There were still concerns regarding Council preparedness for this upcoming vote, as this is largely an inexperienced membership. *LT* suggested training for new Council members on the Unfunds process in the near future.

Adjournment
GG adjourned the meeting.

HIV Health Services Planning Council
Spring Unfunds Working Group

June Report

Meeting Date/Time: Monday, June 05, 2000, 4:00 – 5:00 PM
Members Present: Gene Gowdey, I&EC Co-Chair, Ray Combs, Susan Shea, Council Co-Chair, Margot Antonetty, SFDPH – Housing Services
Others Present: Jim Illig, HIV Contractors Assn., Marcy Fraser, Continuum, , Charlotte Bobek, Positive Health Program - W86, Chris Callandrillo, CCASF, Russ Zellers, HHS

Call to Order
GG gave a call to order.

Introduction of New Participants
It was noted that participants were familiar to one another.

Review and Approval of Agenda
No additions were made. Agenda approved.

Review and Discussion of Draft 4 – Unfunds Policies and Procedures
SS introduced Draft 4 of Proposal for Unfunds for discussion. Participants reviewed the new Draft. *SS* read through the draft, highlighting some points in Draft 4. She stated that the first section was a definition of Unfunds. After a discussion, regarding the dates of Spring/Fall Unfunds, in the document, *SS* emphasized that the Draft was not set "in stone" as in the dates cited in the Draft but were included to give an "idea" and "guidance" to the timeframe that the procedures would follow. JI suggested that terminology used not be attached to a timeframe since it might be too restrictive, i.e., Spring – Rollover Funds. *GG* thought that there should be a cut-off date for Fall Unfunds.

After some discussion under the Program Infrastructure Support section, the second paragraph was deleted after the first paragraph, which was changed to read – "... HHS would distribute in the easiest possible manner.". Some additional deletions and wording changes were made in the third paragraph. Under "Contractors not eligible..." item C was deleted, and would be reviewed after the first year of the P&P was in effect. The addition of "programs in their first year of funding" was added. *RZ* raised the issue of unusual situations, i.e., a burned building that needed rebuilt, how would that be handled? It was felt that in emergency situations the contractors would have to approach the AIDS Office regarding the situation. It was expressed that in the current climate of diminishing grants in HIV/AIDS the money just isn't available to remedy situations that were more easily handled in the past.

VOTE – To forward Final Draft of Policies and Procedures to Council for Approval
Due to on-going discussions regarding clarifications of various points in the Draft and time restrictions; *SS* suggested that she revise the Draft into a final form based on points of agreements. She would contact participants regarding the final Draft for review and agreement on items that needed clarification.

Old or New Business
No additional business was brought forward.

Adjournment
GG adjourned the meeting.

HIV Health Services Planning Council
Implementation and Evaluation Committee

June Report

Meeting Date/Time:	Monday, June 05, 2000, 5:00 – 7:00 PM
Members Present:	Gene Gowdey, I&EC Co-Chair, John Conley, SM Co. Health Dept
Others Present:	Russ Zellers, DPH/HIV Health Services, Jim Illig, HIV Contractors' Assoc., Celinda Cantu, HHS, Laura Thomas, DPH/HHS, Michelle Long-Dixon, HHS, Marcy Fraser, Continuum, Chris Callandrillo, CCASF, Tom Calvanese, TARC, Dana Van Gorder, SFAF
Next Meeting:	Monday, June 15, 2000 25 Van Ness, Room 330-A, 5:00 PM – 7:00 PM

Call to Order
GG gave a call to order.

Introductions of New Attendees
No new participants were present.

Review and Approval of Agenda
No new items were added. Agenda approved.

Discuss process for monitoring/evaluating/follow-up for AIDS Office Implementation of Council Priorities
SS spoke about the issue of reviewing other committees and the AIDS Office and the Implementation and Evaluation Committee about Council prioritizes. *RZ* suggested a service categories working group. *JI* expressed concern about the level of details from the Council about Contractors' grants from AIDS Office. This was considered, but felt that at the same time the need to be pro-active versus reactive. There was concern expressed about the lack of Council involvement in committee work. *RZ* suggested that the AIDS Office take the lead on the working group with a one-month report back.

Considerations for San Mateo/Marin Counties with respect to prioritization
JC requested that the counties remained as "held harmless" by Council. He discussed the impact of AIDS cases versus funding. He stated that he requested *LT* last September to put together a County Report. *JI* asked that a report be done looking into Title I and Title II dollars and the General Funds matching. He felt that membership from the counties be increased to three persons per county based on representation of AIDS cases. *LT* stated that she could supply members with the County Report as requested. Both *SS* and *JC* reported that efforts have been made to increase counties participation. There have been some Council members who have now visited San Mateo and Marin Counties. A Council meeting in those counties has been considered.

Review status of Unfunds Policies and Procedures, Draft 4
The current document is in its 5th Draft at this time.

List of Special Projects
SS presented a draft of the Unfunds requests. She reported that Council would use some of the Unfunds to cover deficits. *RZ* introduced letters of special needs funding requests that he received from Contractors. Participants discussed the new funding requests. While the participants understood the need it was felt that such request to Council couldn't continue in the face of dwindling resources. The importance of the policies and procedures for Unfunds was stressed. *GG* felt that there shouldn't be a decrease in dental dollars. There was some discussion about Title F dollars allocation. *SS* asked that the issue of Title F be placed on another committee agenda, and to leave levels as is and do a an information/educational piece with the Title F administrator in Washington, DC

Old or New Business
No old or new business reported.

Adjournment
GG adjourned the meeting.

HIV Health Services Planning Council
Housing Committee

June Report

To:	Members, HIV Health Services Planning Council
Meeting Date:	June 7, 2000
Meeting Place:	25 Van Ness Ave., Room 330-A
Members Present:	Ray Combs, Catherine Geanuracos, Fernando Gomez, and Ali Riker (Chair)
Others Present:	Elizabeth Colomello, SFRA; Amy Cunninghis, SFAF; Danielle Dulaine, Mayor's Office of AIDS & HIV Policy; Steven Feeback, minutes; Daisy Leyva, DPH (Housing); Laura Thomas, DPH-HHS; and Deidre Wan, Rainbow Church/Bayview-Hunter's Point.
Next Meeting:	Wednesday, July 5, 2000, 25 Van Ness, Room 330, 3:00-5:00 PM

Introductions

Update Re-envisioning AIDS Emergency Housing

Daisy Leyva summarized her written report. This work group has been meeting for the past six months in order to develop a program that promotes housing stabilization and provides emergency housing in a higher quality setting with on-site support services. The work group has decided to recommend a single program that includes both emergency and transitional housing components at one site. DPH-Housing Services would like to further develop this proposal into an RFP by August 2000. Many of the details of this RFP must still be worked out, with additional input. *Ali Riker* noted that this work group resulted from last year's process within the Planning Council in relation to some of the priority needs such as emergency vouchers and improving the quality of emergency housing.

HOPWA Update

AR gave a brief report concerning the demographic profile of people who obtain housing via the HOPWA subsidy program. It continues to be a problem that people of color are not being served in significant numbers.

Housing Wait List Report

Amy Cunninghis presented a report about demographics also. The statistical breakdown dealt with ethnicity, income, gender and age as correlated with referrals to Residential Care Facilities (RCF/CI) as well as the placements in those facilities—the housing that involves highest level of medical care. The data come from the Housing Wait List process. She also presented a chart containing the "Current Referral Pool," made up of people who have been through the second stage of approval for referral to four different types of housing (low level care, high level care, subsidies, and transitional). Everyone was concerned about low rates of placement.

Un-funds

AR spoke about the recommendations from this sub-committee. The financial totals are not available yet for "Spring Un-funds," but the I&E Committee is proposing three categories for the potential use of any money. It was decided that the top three Housing Sub-Committee priority projects would be strongly supported. These recommendations are designed to implement the Council's previously adopted set of priorities.

Needs Assessment

Laura Thomas reported some of the Housing-related information contained in the Harder +Company study. Michael DeMayo would like to have additional questions that focus any additional analysis to now be undertaken. Laura will report back to Michael and may suggest that he come to the July meeting of this committee to amplify the analysis of unmet needs and of the population that can be classified by the Housing questions as homeless.

SPINS Proposals

The Redevelopment Agency has applied for this HUD grant money. Theirs is a project focused on low income people with AIDS who are attempting to return to work, with a program component that includes a number of homeless people. Overall, it is tied in with the partial rent subsidies funded by HOPWA. Another SPINS application was submitted by Rainbow Church and is designed to increase the amount of permanent housing available in the Bayview district. This program would serve women with children. Yet another SPINS proposal was submitted by the Dept. of Public Health in conjunction with the Forensic AIDS Program in order to better serve people coming out of jail. This program includes peer advocacy and the proposed plan would add a housing component. It would permit up to 18 months of housing.

Meeting Time

Ali reported the results of her survey of people who had attended committee meetings in the past. She found that the majority of people preferred the current day and time for the meeting.

HIV Health Services Planning Council

PWA Caucus

Meeting Date:	June 7, 2000
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Veronika Cauley (Co-chair), Ray Combs, Gary Harrell, Jim Mitulski (Co-chair), Rob Whitford, and Eric Whitney
Others Present:	Alliena Baker, Filipino Task Force on AIDS (FTFA); Rami Banaag, FTFA; Richard Bargetto, HIV Consumer Rights Advocacy Project; Steven Feeback, minutes; and Margaret Lacson, FTFA.
Next Meeting:	Wednesday, July 6, 2000, 25 Van Ness, Room 330, 5:30-7:00 PM

Welcome and Introductions

Veronika Cauley announced that she would be receiving an award, along with some other people who've been very active in the fight against AIDS: Billy Pick, Diane Felix, and Bill Barnes. It's an event that is celebrating Lesbian/Gay/Transgender Pride Month sponsored by KQED.

Public Comment

Margaret Lacson explained the background of a current problem in providing services to the Filipino community. A grievance lodged against one of the members of FTFA's volunteer Board of Directors, then satisfactorily resolved through the use of Richard Bargetto's office, has since become a point of contractual dispute. She said that FTFA has 12 years of providing services and providing a sense of community to HIV-positive people in the Filipino community. Their staff includes a number of people who speak Tagalog. The operating budget for their program of direct services comes through a CARE contract to the API Wellness Center, and a sub-contract to FTFA. The problem that arises now is that the API Wellness Center has terminated the sub-contract, leaving FTFA without funding for direct service provision. The Dept. of Public Health (Mitch Katz) has said that his office doesn't want to get involved in the dispute, because a Memorandum of Understanding (MOU) governs the relationship between the two agencies. FTFA clients spoke about a lack of culturally sensitive services and Talgalog speaking staff at the API Wellness Center. They said the grievance, not even the result of a client complaint, was being used as an excuse to take over a contract and obtain more money. *VC* spoke forcefully in favor of trying to do something to help the clients involved with FTFA. *Eric Whitney* talked about MOUs, which he described as a mechanism instituted by the AIDS Office to bring about collaborations. He sees something amiss when a mechanism for collaboration is subverted by contractual language that gives the power of termination totally to one partner of the agreement. Further, he feels that the contract was awarded in the first place because of the expertise of FTFA, as a community agency. The community relationship was central to the health service at the time the contract was written and approved. This shouldn't be changed at whim, with no due process except 30 days notice. This is supposed to be about providing services, based upon agency collaboration. *Ray Combs* agreed with Eric. Margaret Lacson reported that a protest had been called for the following day in front of City Hall. Eric volunteered to write a set of letters on behalf of the PWA Caucus. The Council members who were present voted unanimously (6-0) to support the call for Eric to write such a letter.

Long Range Planning/5-year Strategy Task Force

EW gave a brief report on how the Council was getting this process underway. He called for broad participation and input from diverse sectors, including a significant number of People with HIV/AIDS.

HIV Consumer Rights Advocate's Report

Richard Bargetto distributed copies of his written report for the month of May 2000. As in prior months, his report covers a summary of cases that had been pending as well as the new cases that have arrived on his desk. Richard's work received high praise from Caucus members.

Community Forums

Tenderloin AIDS Resource Center—TARC—is still prepared to help with the next community forum. *Jim Mitulski* thought about the option of waiting until the end of July to do this one. That idea was agreed upon by other members.

HIV Health Services Planning Council

Membership Committee

Meeting Date:	June 8, 2000
Meeting Place:	25 Van Ness Ave., Room 330-A
Meeting Time:	5:30 to 7:00 PM
Members Present:	Laura C. Guzman (Chair) and Eric Whitney
Others Present:	Steven Feeback, minutes; and Laura Thomas, SFDPH.
Next Meeting:	Thursday, July 6, 2000, 25 Van Ness, Room 330, 5:30-7:00 PM

Introductions

Review of Member Attendance Levels

Eric Whitney updated the attendance records. Some members are falling short of the requirements and will be receiving letters. But, others were high achievers in their attendance at meetings during the first quarter. Those receiving thanks and gratitude for top attendance were Gene Gowdey, Stephan Oxendine, and Jim Mitulski, in addition to co-chairs Eric and Susan Shea. A reminder that these attendance records are calculated on the basis of quarterly periods—the second quarter is now closing at the end of June. The Membership Sub-Committee is also encouraging everyone on the Council to make their committee selection in order to fulfill the attendance requirements. *Laura Guzman* said she will prepare letters to some of the members.

Discussion also centered on committee assignments. At a previous council meeting, members were asked to rank order their choices for council committee assignment. Most members returned their choices, and all persons were given their first choice for assignment. It was noted that several members reported interest in certain committees, but have never actually attended the meetings. It was decided that these members would be contacted individually and asked to commit to a committee.

Other Business

Laura Thomas has sent in some of the required paperwork, but a few members have not filled out their forms for the State of California Fair Political Practices. *EW* mentioned the Council's long-range planning process recently underway.

HIV Health Services Planning Council
Steering Committee

June Report

Meeting Date/Time: Monday, June 12, 2000, 5:00 – 7:00 PM
Members Present: Eric Whitney, Susan Shea, Council Co-Chairs, Laura C. Guzman, Membership Chair, Gene Gowdey, IEC Co-Chair, Jeff Klausner, SFDPH
Others Present: Laura Thomas, HIV Health Services, Louise Davis, SFDPH Intern
Next Meeting: July 10, 2000 25 Van Ness, Fifth Floor Conference Room, 5:00 PM – 7:00 PM

Call to Order
SS gave call to order. .

Review of Council Agenda
SS reviewed Council agenda. She spoke about the Steering Committee's work and purpose for the benefit of those visiting the Committee meeting. *Jeff Klausner*, SFDPH reported that he had a few items to discuss with the Steering Committee. These items included: (1) by-law amendment changes in voting, (2) dealing with unruly persons at Council meetings, (3) a Council's endorsement of a Guidance for STD Clinical Preventive Services for PWA/HIV proposal and (4) membership attendance guidelines. On item #1, JK stated that article 4, section 3should be changed to a simple majority vote with abstentions counting as a non-vote. *SS* stated that the item #1 would be appropriate for the Membership Committee to review. On item #2, it was suggested to promote a zero tolerance for unruly behavior, that City Hall security be present during Public Comment and a timer be set and enforced during any individual's comments. *SS* added that a number could be given out to those wishing to make a Public Comment. On item #3, *SS* suggested a Council letter of support. *LT* suggested an STD/HIV educational presentation in August for Council members. *SS* suggested the item be referred to the Health Care Working Group and see about adding this to contract language.

HIV Health Report
LT reported that *Charlotte Bobeck, Catherine Lions* or someone else from WIDS would speak about Integrated Service Providers. She would provide the name(s) to Co-chairs. She reported that she would give the Ryan White Reauthorization update.

Housing Committee
LT reported there would be a report back on the "Revisioning Listing" Committee and the HOPWA Loan Committee.

Steering Committee Report
LT or *EW* will present information on the Five-Years Plan Working Group. There will be a request for the Six-Months planning report from the various committees. In addition there will be a statement regarding the nature of Public Comments given so that all members would be aware of appropriate Council etiquette to enforce and inform others in the future.

IEC Report
GG reported that he will be on vacation so *SO* would present the IEC report. He reported that there would be two votes presented to Council; (1) a Policy and Procedure for Unfunds and (2) Unfunds Allocation for Rollovers.

Membership Report
EW reported that there are no new nominations. *LCG* reported there would be an update on Council membership attendance records, and a notice of Committee assignments. *SS* spoke about working with Membership on an educational piece perhaps a directive survey to members. *LCG* would report on "what it takes" to be in good standing and encourage participation in committee work.

PWA Caucus Report
EW reported on a sensitive emerging issue about contractors from clients that came to the PWAC. There was discussion about the role and concerns of the PWA, Council and Council staff in specific systemic issues. He reported that all concerned parties have been contacted to elicit their statements around the issues. *SS* requested that the Co-chairs discuss the issue at their next meeting particularly around the role and involvement level of the HIV Consumer Rights Advocate. *EW* reported that the Tenderloin Community Forum would be in July as a collaborative effort with TARC.

New Business
EW asked for clarity on the 7/3 IEC whether it should be cancelled or not since 7/4 is a holiday.

Adjournment
SS adjourned the meeting

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Minutes, June 26, 2000 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved at next council meeting

I. Call to Order

4:55 PM

Eric Whitney announced that the meeting had to be moved from its usual location in the Mayor's Conference Room. A scheduling change took place at the last minute, and it was decided to use another room in City Hall on the same floor in order to accommodate people who would not want to walk to another building.

II. Roll Call

See Attachment A, Column 1. A quorum of the membership was not present, but the meeting moved forward, anticipating late arrivals delayed by the room change.

III. Review and Approval of Agenda

It was accepted without revision, by consensus.

IV. General Announcements

Bob Teague made an announcement about the 4th International Hepatitis C Conference, which is scheduled to take place in San Francisco on August 10-13, 2000. *Ray Combs* made an announcement about a community benefit for the Native American AIDS Project, which was scheduled for Saturday July 1, 2000. *Bart Casimir* noted the Living Sober Conference taking place in the Bay Area during the Independence Day long weekend.

V. Public Comment

Michael Petrelis said he would be tape recording during the meeting. He said he was particularly interested in the update report related to reauthorization of the Ryan White CARE Act. He spoke about "San Francisco Exceptionalism" as it relates to a debate between two members of Congress as well as a dispute between advocates from San Francisco and Los Angeles.

VI. Review and Approval of Minutes

05/22/00 Council Meeting Minutes – A misspelling/misidentification on one presenter was noted and corrected. Then a motion to approve the 05/22/00 minutes was agreed upon by consensus.

VII. Reports

VIII. HIV Health Services of DPH Report

Michelle Long Dixon passed around a written "1st Quarterly Report to the HIV Health Services Planning Council." The first quarter of this contract year includes the months of March, April and May. She gave a contract status report, saying that 77 CARE contracts and MOUs were in various stages of development and processing: 31 were already certified, 13 were in the process of certification, and 33 were in the review/negotiation phase. She summed this up as being slightly ahead of schedule. Next, she said that there were some Carry-forward funds from the CARE Title I 1999-2000 grant, as of 6/26/00 these funds totaled $643,625. HRSA approved the idea of using a portion of this to offset a drop in funding for the current 2000-01 grant. The remaining balance is $70,447. Next, she reported a grant application submitted to the Office of Minority Health for Technical Assistance and Capacity Building to serve AIDS service organizations in communities of color within the EMA. Lastly, she reported on the successful start-up of a new Early Intervention Program for the Bay View Hunters' Point neighborhood of San Francisco. She explained that it not only is providing the required services for those who are HIV positive: a) medical evaluation and treatment, b) case

management, and c) health education. It has also built an extended set of collaborative relationships in order to offer prevention, HIV testing, mental health, substance abuse, outreach, and adherence promotion. All this is based out of the Southeast Health Center, run by DPH, located at 2401 Keith Street. It is operational and enrolling clients. This Early Intervention Program is funded for $350,000 per year by the State Office of AIDS.

Laura Thomas gave the Ryan White CARE Act Reauthorization update since this issue affects the Council's planning process for HIV care and services over the course of the next few years. The Kennedy-Jeffords Bill passed the Senate. In the House of Representatives, Rep. Coburn and Rep. Waxman are working on a version of the Reauthorization, and final language for their bill will be distributed. Laura said she will notify Council members further about the House version. Rep. Pelosi is very active in working to ensure that the formula for fund allocation does not work against this Council's plan to provide high levels of health service to HIV+ clients in San Francisco. Laura said that there are probably going to be some significant differences between the House and Senate bills right up to the final stages when they have to be reconciled.

IX. Presentation--Integrated Services Provider--WIDS

Naomi Prochovnick was introduced. The program she manages is called Women's Integrated Delivery System, which is a collaboration between Lyon-Martin Women's Health Services and the UCSF Positive Health at San Francisco General Hospital (Ward 86) and BAYPAC. The core of the program is primary healthcare along with case management and a host of other auxiliary services. This program serves the majority of HIV+ women in San Francisco with a complete continuum of care. She talked about the importance of peer advocacy for clients, as a way of extending the ability of case managers to serve sizable caseloads. Peer advocates act as a bridge between services and they are usually HIV+ themselves. The challenges have been numerous. For one thing clients have many pressing issues, among them multiple diagnoses and homelessness in addition to HIV/AIDS. There are also many challenges in operating a collaborative program, for example blending together agencies that have wildly divergent cultures, supervising staff at multiple sites and the insufficient amount of indirect costs being provided by the contract to cover startup plus a multiple site, multi-phase program. *SS* asked about client numbers and budget. There are about 200 clients receiving medical care at one or both sites while receiving case management. The budget is over $300,000 per year in two contracts. *KW* asked about the integration of primary collaborating agencies versus program enhancements. The collaboration itself addresses the primary medical and case management services with access to peer advocacy, treatment advocacy, and emergency housing. These are offered at three sites. Other service components not addressed by the collaboration had to be pulled in on a less formal, less contractual basis. Overall, it's a single unified program that clients can enter using any of the sites. *LCG* asked what outcomes have been seen and has the integrated system helped clients (more than the prior programs for women at Lyon-Martin). Naomi explained that clients felt much more taken care of. They don't have to make "either/or" choices. Clients can prioritize taking care of their medical care without risking the loss of an array of support services that they've come to depend on. In the past, it's been a challenge for clients who had felt at home at Lyon-Martin; then their medical progression required more advanced care through Ward 86 at General Hospital. Now, they keep a very safe case management relationship while getting more medical care. The no-show rate has also dropped. She stressed the importance of women's services with care ranging from peer advocacy through advanced, complex HIV-specific medical care, all relating to the specific issues of women. She was next asked about the availability of childcare services. She said that the connections with family service agencies permit childcare on-site, while also helping with respite care. She was next asked what steps might be taken to provide greater support and make the integrated services such as WIDS more workable. She appealed for more time for

planning and evaluation. Their experience has been "to hit the ground running" with a non-stop schedule. The strength of the program is that the staff is made up of providers rather than managers. They would like to take some time for coordination and planning.

X. Implementation & Evaluation Committee

Eric Whitney first referred Council members to proposals from the UNFUNDS Working Group in their packets and to the written opinions being shared by the HIV Contractors Assn. and the SF Dept. of Public Health. *Susan Shea* took over and went through some recent history about the methods associated with "unfunds." In the past, the Planning Council has not had a policy or a procedure for dealing efficiently with unspent money. Instead, an ad-hoc approach has been used, often generating tension and consuming too much time. The current co-chairs had set as one of their priorities the development of a well-organized approach, by involving the Contractors Association, DPH AIDS Office staff and Council members. It is hoped that this proposal submitted tonight forms the basis of dealing with these funds that come available perhaps twice a year. She listed the votes scheduled for this meeting and reminded members about voting requirements. The Parliamentarian established that members should abstain if they have a conflict of interest. This will lower the voting numbers, but has no impact on the quorum requirements for conducting business. Members should feel free to express their opinions about the proposals, and yet should refrain from taking part in the vote if their organization stands to gain or lose something as a result of the vote. Public Comment will be permitted again at the close of this discussion before voting takes place.

The first part of the proposed Policy and Procedure is to establish three categories for the use of "unfunds." These are 1) Program Infrastructure Support, 2) Program Enhancements and Stabilization, and 3) System Development and Evaluation. There is no priority order to the categories, and each cycle of any given year will still bring a set of decisions about how to allocate any funding among the three categories. *Kelly Wallace* spoke in favor of category #1, giving examples of how community organizations and agencies are operating with shrinking budgets that don't allow capacity to include infrastructure purchases, for example a new telephone system. This definitely has an impact on client services.

The second part of the proposed Policy and Procedure deals with the question of which programs are eligible for category #1. About 26% of all the HIV care programs in San Francisco operate under auspices of the Department of Public Health, where budgeting is handled according to a set of rules that is somewhat different from the prevailing set of operating principles for independent agencies. The HIV Contractors Assn. would prefer that programs under the umbrella of DPH be declared ineligible for Program Infrastructure Support funding. The Association circulated a memo opposing the inclusion of city-run programs in the distribution of available "unfunds." *Michael Shriver* expressed his view that the memo from the HIV Contractors Assn. was inappropriate and not factually accurate. He views the HIV care network as a partnership, and he feels that in this case one part of the partnership is trying to disqualify the other part of the partnership. He thinks both should be eligible for the re-distribution of any unspent funds. *Gary Harrell* agreed, saying both are already eligible in his mind. *Jeffrey Klausner* also characterized part of the argument by the Contractors Assn. as untrue, with regard to City budget procedures. *Laura Guzman* attempted to clarify part of the Contractors' intent about the way in which shrinking budgets impact independent non-profit service organizations. Worker salaries are falling further behind what the City can pay its employees, therefore non-profits are experiencing higher levels of staff turnover than DPH programs. *Ken Pearce* asked for comment by the HIV Contractors Association. Jim Illig, who is the head of that group, spoke in favor of fairness, which he said was the goal of this policy. He explained that other revenue streams have been available for DPH programs to fall back on in order to pay the rent and other operational costs. He said that the overall City budget had

increased by 25% over the past five years. During those same years, the independent non-profits have generally experienced level funding, with no cost-of-living wage increases. While the category of Program Infrastructure Support is not designed to address the salary issues directly, the problem that non-profit organizations face in attracting and retaining good staff must be addressed by several means, because it is having a serious negative effect on client services. Next, Michelle Long-Dixon was asked to re-state the position of the Dept. of Public Health on this issue. She said she was not in a position to advocate for DPH programs, but would simply like to clarify that many DPH staff in jobs funded by CARE contracts are in the same difficulty as staff at CBOs. Further, the DPH programs are obligated to provide levels of treatment and service that may go beyond what is required by their contracts whereas CBOs are not. She said that a great deal of effort has been put into improving their cooperation with independent non-profit service providers, and she is therefore trying to minimize situations like this one, which cause friction and competition. She also doesn't anticipate that much money will be left unspent and available for this category of re-distribution. *MS* moved that both community-based contractors and DPH program entities be declared eligible for these "unfunds." It was seconded. *KW* said he supported the motion that both be eligible. He also spoke of how such situations are handled in Marin County, with CBOs having some degree of preference over the County's direct programs. He didn't want to exclude anyone, but still wanted to acknowledge that CBOs need greater support. *Jeff Byers* reiterated that the only issue here is eligibility. It was then motioned to close discussion on this topic. Roll call vote was taken on a motion that both CBO and City programs would be considered eligible for Program Infrastructure Support. It passed by a vote of 13-1, with 5 abstentions (see Roll Call sheet, Column 2).

SS next asked for discussion about other aspects of this Unfunds Policy and Procedure document, such as the timelines or other eligibility requirements. There was no further discussion, so it was moved and seconded that the entire document be approved. This motion was passed by a vote of 18-0, with 1 abstention (see Roll Call Sheet, Column 3).

The next part of the "unfunds" discussion had to do with recommendations from the I&E Committee concerning projects that had been forwarded to the committee for consideration. Members had a chart that included a rank ordering of these projects. *KP* asked how these projects came to be identified. The top-ranked ones came out of a prior process known as prioritization, as well as the Council committees trying to implement those priorities. The lower-ranked projects were unsolicited requests probably based on the schedule and the procedures in prior years. At the bottom of the list are two items that have been taken off the table but not forgotten. *SS* said that discussion should focus on the rankings, rather than on dollar amounts. SF-DPH, will implement the list of projects in priority order and will use available funds to support as many of the projects as possible. It is planned that the same list will be used for both cycles of unfunds this year, per the timelines just approved (spring and fall). Members had several questions in order to understand the chart of I&E rankings. The 1st priority project concerns a Task Force to study a number of issues related to case management, peer and treatment advocacy, practical support and attendant care. *SK* asked what criteria had been used in order to establish the rankings. *SS* responded that the criteria were formulated out of historical precedents in the prioritization process and the work of various Council committees. Since the Council will likely be working with decreased funds in future years, it was determined that the top priority should be an effort to better understand the relative impact of the services collectively identified under case management. The 2nd priority item has to do with eviction prevention and grows out of the housing crisis we're experiencing. The food and household vouchers requested are used primarily as adherence assistance incentive or improving access to primary care, which received a number 3 ranking. Another eviction prevention program received the 4th place ranking. The next question had to do with

distinguishing between the two eviction prevention efforts, both of which had been put forward by the Housing Committee. *Ali Riker*, chair of Housing, explained the two distinct projects. *GH* asked for clarification of how the ranked projects would be handled by spring and fall cycles of unfunds. *BC* asked about the absence of mental health projects from the list. No requests had been forwarded this year to the I&E Committee that fell under the category of mental health services. Eliminating a wait list for services had been identified as one of the Council's objectives last year, but this had been accomplished through the regular contractual process. *LCG* put forward what was termed a friendly amendment to remove the 7th, 8th and 9th priority projects from this list because they did not fit into the categories approved in this meeting as part of the overall Unfunds Policy and Procedure. This was passed by a consensus vote. *AR* and *JK* expressed some perceived problems in the rankings. *AR* wanted greater support for eviction prevention, but decided to defer to the committee's rankings for now, knowing she has another chance in the fall. *JK* argued for the importance of the project that had been given the 5th place ranking—a project designed to better integrate home health and medical care with substance use providers, especially residential substance use facilities, to enable clients to stay in residential facilities. He argued that it's a small amount of money ($1-2,000) and is an issue that should be addressed sooner. He put forward a motion to move the ranking of this project to number 3. This motion was seconded. A few comments pro and con were offered and Roll Call was taken on this amendment. It came out 5 yes and 13 no (see Roll Call Attachment A, Column 4), so the change in ranking was not agreed to. Then a vote was taken for approval of the project ranking. It passed by 18-0 (Attachment A, Column 5).

A motion was made and approved by consensus to extend the meeting by 10 minutes.

XI. PWA Caucus

EW reported that the next community forum that the Planning Council will sponsor had been scheduled for the end of July (the 25th at 6:00) and will be held in conjunction with the Tenderloin AIDS Resource Center (TARC). *KW* asked that the HIV Consumer Rights Advocate's report always be included in the packets that get mailed out prior to meetings. And, Richard Bargetto will be presenting to the Council during its August meeting.

XII. Membership Committee

Laura Guzman said that the highest achievers in attendance during the first two quarters of this year weren't present tonight to receive accolades. She also said that some members would soon be getting letters indicating a probationary status as a result of not meeting the minimum attendance requirements. She asked members to attend committee meetings and noted that the 5-year planning committee had been added to the slate.

XIII. Steering Committee Report

EW passed around two items: some information from HRSA and a conceptual framework for formulating short-term objectives. The Steering Committee is recommending that each of the committees contribute to a proactive six-month process, which begins with stated work-plans and then is able to document progress. *EW* also mentioned that one of the Council's members had been ill and hospitalized recently, Michael Meehan.

XIV. New Business

XV. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

June 26, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*										
2. Hazel Betsey	*HB*										
3. Jeff Byers	*JB*	P	Y	Y							
4. Bart Casimir	*BC*	P	Y	Y	N	Y					
5. Veronika Cauley	*VC*										
6. Raymond Combs	*RC*	P	Y	Y	N	Y					
7. John Conley	*JC*										
8. Mark Dunlop	*MD*	P									
9. Gregory Edwards	*GE*	P	Y	Y	N	Y					
10. Catherine Geanuracos	*CG*	P	B	Y	Y	Y					
11. Fernando Gomez-Benitez	*FGB*										
12. Gene Gowdey	*GG*										
13. Laura Carcagno Guzmán	*LCG*	P	B	B	N	Y					
14. Gary Harrell	*GH*	P	Y	Y	Y	Y					
15. Siddiq Jihad	*SJ*										
16. Sam Kaplan	*SK*	P	Y	Y	N	Y					
17. Jeffrey Klausner	*JK*	P	Y	Y	Y	Y					
18. Gene London	*GL*	P	B	Y	N	Y					
19. Carmen Madríz	*CM*										
20. Michael Meehan	*MM*										
21. Allen Meyer	*AM*	P	B	Y	N	Y					
22. Jim Mitulski	*JM*										
23. Gregory Neumark	*GN*	P	Y	Y	N	Y					
24. Jorge Ortíz	*JO*										
25. Stephan Oxendine	*SO*										
26. Ken Pearce	*KP*	P	Y	Y	N	Y					
27. Alissa Riker	*AR*	P	Y	Y	Y	Y					
28. Susan Shea	*SS*	P	B	Y	N	Y					
29. Mike Shriver	*MS*	P	Y	Y	Y	Y					
30. Bob Teague	*BT*	P	Y	Y	N	Y					
31. Kelly Wallace	*KW*	P	Y	Y	N	Y					
32. Robert Whitford	*RW*										
33. Eric Whitney	*EW*	P	N	Y	N	Y					
34. Mary Jane Wood	*MJW*										
			Eligib.	Policy	Amend	Ranking					

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

July 24, 2000

AGENDA

4/00
ncelled

MEETING HAS BEEN CANCELLED FOR MONTH OF JULY ONLY

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Upcoming meetings:

Day	Date	Type	Location	Time
Tues	7/25	5-year Plan Working Group	25 Van Ness, Room ?	3:00 – 5:00 PM
Wed	8/2	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	8/2	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:00 PM
Thurs	8/3	Membership Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	8/7	5-year Plan Working Group	25 Van Ness, Room ?	3:00 – 5:00 PM
Mon	8/7	Implementation & Evaluation Committee	25 Van Ness, Room ?	5:30 – 7:30 PM
Mon	8/14	5-year Plan Working Group	25 Van Ness, Room ?	3:00 – 5:00 PM
Mon	8/14	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	8/21	Implementation & Evaluation Committee	25 Van Ness, Room ?	5:00 – 7:00 PM
Mon	8/28	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

HIV Health Services Planning Council, 1540 Market Street #301, San Francisco, CA 94102
San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, 5th floor

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DRAFT HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

August 28, 2000

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes**, 6/24 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *Implementation & Evaluation Committee* CBC Initiatives and Prioritization of Projects — **VOTE**	**4:55 PM**
	• *HIV Health Services of SF-DPH* Application Budget — **VOTE**	**5:35 PM**
	• *San Francisco AIDS Foundation* Reauthorization of CARE Act	**5:50 PM**
Break		**6:00 PM**
	• *Jeff Klausner, Director of STD Prevention & Control Services of SF-DPH* Presentation on Sexually Transmitted Diseases	**6:15 PM**
	• *PWA Caucus*	**6:45 PM**
	• *Membership Committee*	**6:55 PM**
	• *Housing Committee*	**7:05 PM**
	• *Steering Committee* 5-year Plan Working Group Open Co-Chair Nominations	**7:15 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Wed	9/6	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	9/6	PWA Caucus	25 Van Ness, Room 330	5:00 – 7:00 PM
Thurs	9/7	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	9/11	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	9/18	5-year Plan Working Group	25 Van Ness, Room 330	3:00 – 5:00 PM
Mon	9/18	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	9/25	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	10/2	5-year Plan Working Group	25 Van Ness, Room 330	3:00 – 5:00 PM
Mon	10/2	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	10/4	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM

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HIV Health Services Planning Council
Implementation and Evaluation Committee

June Report

Meeting Date/Time:	Monday, June 19, 2000, 5:00 – 7:00 PM
Members Present:	Ray Combs; John Conley, San Mateo Co. Health Dept; Greg Edwards; Catherine Geanuracos; Gene Gowdey, I&EC Co-Chair; Bob Teague; Mary Jane Wood; Susan Shea and Steve Oxendine, Council Co-Chairs
Others Present:	Russ Zellers, DPH/HIV Health Services, Jim Illig, HIV Contractors' Assoc., Laura Thomas, DPH/HHS, Michelle Long-Dixon, HHS
Next Meeting:	Monday, July 17, 2000 25 Van Ness, Room 330-B, 5:00 PM – 7:00 PM

Call to Order
GG gave a call to order.

Introductions of New Attendees
No new participants were present.

Review and Approval of Agenda
No new items were added. Agenda approved.

Discussion regarding July 3rd meeting of IEC
Members agreed to not meeting on 7/3, the next meeting would be 7/17.

Finalization of Unfunds Policy and Procedure
SO had several questions regarding the document. He requested that the acronyms be spelt out for clarity. *SS* explained each point questioned. She reported that the take-home-message was "there is not going to be any money", after the end of the year. *JI* expressed concern that there may not be any money for the Infrastructure Support once the CARE Council reviewed its projects for funding. *SS* stated that she understood the concern but that IEC would review and measure by proportion between the Council and Contractors' unfounded projects from the Falls Unfunds. She stated that the Falls Unfunds, to the degree as was equitable, would be given to the Contractors. *JC* felt that this was as close to a consensus document as the committee could propose. *MLD* suggested that there be a provision spelling out a minimum dollar amount that would activate the process. She withdrew the suggestion when it was pointed out that the document requests that the AIDS Office would be charged with distributing the funds in the most efficient manner.
JI requested that the document state that contractors be defined as NON-PROFITS not to include MOUs with city agencies. *SS* felt that this was a controversial point and felt that it needed to be taken as a separate Council vote. *LT* suggested that the two positions be written and set out with the package for consideration by Council members to vote on. *SS* motioned that Falls Unfunds be considered for all agencies receiving CARE dollars. *MJW* seconded. *SS* stated that an addendum be included with pro and con versions to Council members for voting consideration. The vote was unanimous in favor of the motion and the voting addendum.
MJW requested that a commitment be made from Council that 25 - 30% of funding go to city agencies. She reasoned that in the past there was a similar struggle with unions versus the city and that if the city can do it, it should, to save money. *JC* requested that the Counties not be held by the Policy and Procedure and remain harmless by San Francisco. *SO* stated conversely that the city/county of San Francisco feel free to deal with these considerations, as it needs to and not be boxed. *SS* requested that *JC* craft specific language for inclusion with *MLD*. She reported that it could be added to the first paragraph with asterix noting counties considerations. *MLD* suggested an addition to the third bullet on page three stating where inconsistent of federal/state/county regulations.
Vote on documents with stated addendums – 1 – NO, 8 – YES, 0 – ABSTENTIONS

Current Unfunds Requests Considerations

SS felt that the list needed to be prioritized according to highest need. *RZ* stated that the health care piece would be handled with a consultant and it should read 20 – 25 K. *LT* reported that the case management piece comes up three times and could be condensed as one piece. She reported that Treatment-On-Demand did not get its funding and withdrew its request for matching funding from CARE Council. There was discussion about how viable the request for over 100k were if Eviction Prevention less. It was felt that it would take what it could but that this amount was to maintain a level support present. *SS* asked about a HRSA consultant providing technical assistance on case management and treatment advocacy for Council. It was decided that the AIDS Office would investigate this possibility. After more discussion it was agreed that the priority ranking would be:

1. CM/PA/TA Task Force (assess issue) * look into TA support form HRSA
2. Housing – Legal
3. (Adherence Assistance) Food – Vouchers (2/3rd of available dollars), Household – Vouchers (1/3rd of available dollars)
4. Housing Eviction Prevention
5. Health Care/Substance Use
6. Housing – Harm Reduction
7. RALF
8. Bank Fees
9. Costs Caps (suggested 10k place holder)

SS motioned to accept this ranking of current priorities for Unfunds. *GE* seconded.
Vote was unanimous in favor of accepting ranking of priorities.

Discussion of Six-Month Plan for IEC

Due to time restrictions this item was held until next meeting on 7/17.

Old or New Business

No old or new business reported.

Adjournment

GG adjourned the meeting.

HIV Health Services Planning Council
Implementation and Evaluation Committee

July Report

Meeting Date/Time:	Monday, July 17, 2000, 5:00 – 7:00 PM
Members Present:	Gene Gowdey, I&EC Co-Chair
Others Present:	Russ Zellers, DPH/HIV Health Services, Michelle Long-Dixon, HHS, Celinda Cantu, HHS/AIDS Office, Marshia Herring, HHS/AIDS Office, Joseph Cecere, HHS/AIDS Office
Next Meeting:	Monday, August 07, 2000 25 Van Ness, Room 330-B, 5:00 PM – 7:00 PM

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Call to Order
GG gave a call to order.

Introductions of New Attendees
No new participants were present.

Review and Approval of Agenda
No new items were added. Agenda approved.

Discuss Tentative Draft of Six Month Work Plan (through December 2000)
Since there were not many Council members present to hold a full discussion of the Six Months Work Plan, *GG* asked if there was an update regarding the Falls Unfunds from the AIDS Office to report as it would be involved in the six months work plan. *MLD* reported that it was uncertain at this time as all monies involved are being processed and should be in use.

Set Schedule of IEC Meetings for Next Six Months (through December 2000)
There was some discussion about meeting once a month as workload permitted. *MLD* reported that it might not be feasible if reduction protocols are to be acted upon, with the Unfunds protocols and guidances. *GG* suggested meeting twice a month to keep up to date with pending workload. After some discussion regarding holidays and planned committee work, the following dates were considered for the next six months: 8/7-8/21, 9/18, 10/2-10/16, 11/6-11/20 and 12/4. These scheduled dates are subject to change as the need to adjust them arises for consideration.

Other Old or New Business
RZ suggested that *SO* send out a draft of Unfunds protocol and guidances to members to peruse for the 8/7 meeting. There should be an AIDS Office update to the IEC on priority at the 9/18 meeting.
NH reported on a HRSA piece that she read on priority process guidance. People present thought that this information would be helpful to IEC to consider.
RZ reported on the issue of Cost Caps. *GG* thought the Cost Caps would be given by the Steering Committee. He suggested that the issue be presented during that committee meeting.

Adjournment
GG adjourned the meeting.

HIV Health Services Planning Council
Steering Committee

July Report

Meeting Date/Time:	Monday, July 10, 2000, 5:00 – 7:00 PM
Members Present:	Margot Antonetty, Housing Comm. Co-Chair, Gene Gowdey, IEC Co-Chair, Greg Neumark, Eric Whitney, Council Co-Chair,
Others Present:	Michelle Long-Dixon, DPH, and Russ Zellers, DPH
Next Meeting:	August 14, 2000 25 Van Ness, Fifth Floor Conference Room, 5:00 PM – 7:00 PM

Call to Order
EW gave call to order.

Council Meeting Break
Members agreed to cancel upcoming Planning Council meeting. For a summer holiday break. There was no pressing business to attend to for Full Council. *EW* will contact all Council members of the break.

Six-Month Planning Process
EW stated that the committees should be discussing their six-month plans at their meetings. He reported that he is willing to provide technical assistance on planning and brainstorming if invited to do so by the committee members.

Housing Committee
MA reported that the six-month plan was tabled at the last Housing meeting. She reported that *Johanna Keeely*, Mayor's Office on Homelessnes, would like to give a presentation to the CARE Council on the five-year plan from the Continuum of Care Plan for the Homeless.

Steering Committee Report
EW announced his plans for resignation from Council, in addition he not will he be seeking another term as Council Co-chair in August. He reported that *Steve Feeback* has agreed to provide staff co-ordination. He will work with *SF* to bring him up to speed and to forward the discussion on securing web space to place the CARE Council on the internet for public consumption. *EW* reported that he took a position at Positive Resource Center and will be focusing his energy on his new position.

IEC Report
GG reported that the IEC would be discussing the six-month planning process at its next meeting.

PWA Caucus Report
EW reported that the PWAC would meet to decide on an endorsement for Council Co-Chair to present to Full Council in August.

Adjournment
EW adjourned the meeting

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HIV Health Services Planning Council
Steering Committee

August Report

Meeting Date/Time:	Monday, August 14, 2000, 5:00 – 7:00 PM
Members Present:	Eric Whitney, Susan Shea & Steve Oxendine, Council Co-Chairs, Greg Neumark, Gene Gowdey, IEC Co-Chair, Laura Guzman, Cecilia Chung, Michael Shiver
Others Present:	Michelle Long-Dixon, DPH, Russ Zellers, DPH, Michael DeMayo and Dara Dunbar, Harder & Co., Laura Thomas, AIDS Office, Steve Feeback, HHSPC Staff Support Coordinator
Next Meeting:	September 11, 2000 25 Van Ness, Fifth Floor Conference Room, 5:00 PM – 7:00 PM

Call to Order
EW gave call to order.

Review and Approval of Steering Meeting Agenda
Discussions added included Cost Caps, Client Satisfaction Survey/Quality of Care Task Force, HRSA missive on Council stipend and Substance Use/Mental Health/Home Care Priority Task Force.

HRSA on Council Stipend Expenditure
MLD would report on a HRSA missive on how CARE Council stipends expenses would be handled. It appears to be different than how the CARE Council has approved of how to handle the stipends.

Client Satisfaction Survey
Michael DeMayo, Harder & Co. updated the Steering Committee on the survey. His recommendation is to develop Standard of Care items to access information regarding quality of care. He reported that the agency is committed to providing technical assistance to contractors on developing their quality of care tools and Council products. There was discussion regarding existing and planned for dollars to continue this work to include potentially Case Management, Substance Use, Home Care and Treatment Advocacy, Peer Advocacy and Mental Health. *MLD* advocated a "quick and dirty" process be done rather than to overspend starting from scratch (since some categories are being done here and elsewhere) with monies that remains. *MDM* was asked to present a proposal including the scope of work and budget to IEC at their September 18th meeting.

Costs Caps
Both *RZ* and *MLD* requested for Rollover funds to address cost caps. *SS* asked that it be thought philosophically if it was correct for Council to pay for this if this might be a grantee function, it decide cost caps for positions. She asks, is this evaluative? She suggests that Steering Committee members be prepared to discuss this issue with persons who may consider this a grantee function. *LT* stated that this was under Council legal purview. Members felt that this should be a joint effort and a shared cost venture. The AIDS Office was asked for a proposal and budget for consideration.

Home Care/Other Services (SU/MH) Task Force
RZ spoke about this task force. He asked for names to be forwarded to him to contact to populate this task force. The next meeting is Monday at 3PM. He gave a case example. *EW* asked that *Richard Bargetto*, HIV Consumer Rights Advocate be contacted about this meeting.

AIDS Office Report
LT reported she could ask the San Francisco AIDS Foundation to do an update on Ryan White Reauthorization. She would do a Children, Infant and Women in CARE Report and speak on the Title One Application Budget. There will be a Cost Caps prioritization Update.

Council Presentations
JK will give a presentation on STDs and HIV to Council. He will do so with some others from the Department of Health. This is important for consideration of future direction of prioritizing health of HIV positive persons.
SS reported that Mitch Katz, Thom Coates and Michael Shiver would give a presentation regarding the Prevention policy plan that has been issued from the AIDS Office. There is a planned presentation that has been developed.

Steering Committee Report
EW reported that Co-Chair nominations should be held during this report.

IEC Report
SS reported that there would be a CBC FYI though it may not be noted on the agenda. She reported that there would be an update on the Client Satisfaction Survey update by *Michael DeMayo*.

Adjournment
EW adjourned the meeting

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PWA Caucus Meeting

Meeting Date:	July 5, 2000
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Gary Harrell, Jim Mitulski (Co-chair), Rob Whitford, and Eric Whitney
Others Present:	Steven Feeback, minutes; and Derrick Mapp, Council Support.
Next Meeting:	Wednesday, August 2, 2000, 25 Van Ness, Room 330B, 5:30-7:00 PM

Welcome and Introductions

Rob Whitford talked about the struggle of the Native American AIDS Project. They offer culturally specific services that serve some 60-80 clients, most of whom would not want to go to any other agency for similar services. At NAAP, people with HIV/AIDS receive mental health and alternative healing care in a very supportive environment. Also, Council member Michael Meehan has been sick lately.

Community Forums

Tenderloin AIDS Resource Center—TARC—is still prepared to help with the next community forum. It had been scheduled for Tuesday, July 25th at 6:00 pm. Everyone said they would communicate about the agenda via E-mail. We'll provide the food and drinks. Food vouchers will be available. Other Tenderloin-based organizations will be informed and a press release will go out to the gay papers.

Gay Mens Health Summit

It is hosted this year by the Boulder County AIDS Project and will be held July 21-23. *Jim Mitulski* attended the first one and this is now the second one. The cost to attend is relatively low.

Letter to Mitch Katz

Eric Whitney read a draft version of the PWA Caucus's letter growing out of the discussion during last month's meeting in which we heard from clients and staff from the Filipino Task Force on AIDS. The decision in this case to terminate a Memorandum of Understanding has the affect of disenfranchising the clients. We intend to push for a new feature in future contracts saying that if either party in a major service-delivery relationship defined as contractor-to-subcontractor desires a unilateral change, then the change can only be done through a process that consults with clients about their needs.

Long Range Planning/5-year Strategy Task Force

EW gave a brief report on how the Council was getting this process underway. Eric suggests the PWA Caucus oversee the development work for two sections of the plan: 1) a description of existing barriers to care and weaknesses of the current system, 2) other issues which impact the delivery of services in the EMA. Eric plans to have more discussion on each of these topics at our next Caucus meeting in August. And, he will try to focus a part of the upcoming community forum on an effort to describe some of the barriers to care experienced by clients in the

Tenderloin. Jim sees this effort to elaborate a 5-year strategic plan as an opportunity to focus greater attention on the compelling need that People with HIV and AIDS have in relation to housing. Derrick told everyone about his horrible experience when referred for emergency housing in one of the SRO hotels.

Six-Month Work Plan

EW introduced the need to focus on our next-six-month work objectives. This discussion will take place at the next meeting.

Co-Chair Resignation

EW announced that he was not going to run again for Council Co-Chair and may resign before his term expires. Therefore, he suggested that the PWA Caucus members start thinking about who would be the best person to be nominated by and supported by the Caucus.

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PWA CAUCUS – JULY 2000 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Housing	Peter Claver/Catholic Charities	Eviction	Resolved
2-	Housing	S.F.A.F	Voucher Denied	Pending
3-	Primary Care	U.C.S.F	Patient Notification	Pending
4-	Housing	Derek Silva/Catholic Charities	Quality of Care	Pending
5-	Housing	SFAF	Cultural Competency	Pending
6-	Housing	Restoration House/Ark of Refuge	Transgender Ambiguity	Pending
7-	Case Mngt	API Wellness Center	Alleged Breach of Confidentiality	Pending
8-	Housing	Peter Claver	Guest Restriction & Policy	Pending
9-	Housing	Haight Ashbury Free Clinic	Quality of Care	Pending

1- Client has received an eviction notice from Peter Claver based on allegations of abusive behavior to staff and updated housing needs (client suffers from incontinence). Advocacy Project assisted client with access to Eviction Prevention Collaborative for the initial portion of his defense and then to the ALRP for settlement conference and trial preparation. During the trial stay, Advocacy Project assisted client getting a spot in AIDS Hospice in another state near his family. Client, Catholic Charities & Continuum shared the cost of airline ticket to transport client.

2- Client claims he has been denied housing vouchers from the SFAF due to his disruptive conduct at a SRO. Client claims that he was not in the building at the time of the disruptive behavior and therefore could not have created the alleged disruption. Advocacy Project is investigating the incident to determine the facts surrounding the denial of client's housing voucher and whether the termination was equitable.

3- Client contacted the Advocacy Project about the poor notification that occurred during the termination of his primary care provider at U.C.S.F. Client has re-instituted his complaint after a brief suspension. Advocacy has contacted the U.C.S.F. and is awaiting a reply regarding the circumstances around this specific case as well as the policies regarding patient notification and implementation.

4- Client has filed a grievance regarding noise & harassment by other residents at Derek Silva and the staff's inability to effectively respond to the problem. Advocacy Project assisted client with the initial grievance and is monitoring the complaint. Client is not satisfied with Derek Silva's initial response and will appeal the decision. Advocacy Project is assisting client with that appeal and is monitoring the complaint.

5- Client has filed a grievance with the SFAF claiming that his subsidy was terminated without his full understanding and knowledge. The client, who is hearing impaired, attended a meeting @ SFAF whereby he voluntarily left the subsidy program in order to move in with his partner. At this meeting, client believed his subsidy would be returned if he moved out of his partner's apartment; however, because no translator was present at the meeting, miscommunication occurred. Client is not satisfied with the SFAF's response and will appeal the decision. Advocacy Project is assisting client with his appeal and monitoring the complaint.

6- Client claims that she participated in an intake procedure at Restoration House. When she revealed that she is a "pre-operation" transgender, the client claims the coordinator allegedly stated that "pre-ops do not qualify." Advocacy Project is investigating the policy itself and the veracity of the statement in order to determine whether "anatomy" vs. "identity" can be an appropriate measure to deny housing opportunities.

7- Client received a letter from API Wellness Center discussing the scope of their services and how they might assist him. Client claims that he never consented to have API contact him and that he only wishes to receive services from three ASOs in San Francisco. Advocacy Project is investigating how API obtained his name & address and whether his confidentiality had been breached.

8- Client has been restricted from having visitor's due to his recent behavior after bringing a stranger into the community who later became allegedly dangerous to other resident's and staff. Advocacy Project is investigating whether such restrictions of guest for this client have been made in an equitable manner.

9- Client claims that Haight Ashbury has not appropriately responded to her needs and has filed a grievance on five separate issues relating to quality of care she has received. Client was not satisfied with the initial response from the agency and has appealed the decision to the Executive Director. Advocacy Project is assisting client with the appeals as well as monitoring the grievance process.

NEW CASES

	Type of Service	Agency	Issue	Outcome
1	Housing	Black Coalition on AIDS	Discrimination against Pets	Pending

1- Client completed an in-take procedure with Black Coalition on AIDS/Rafiki House. After being welcomed given the key to his room, BCA claimed that client misrepresented important facts about himself, namely, that he had a pet, and asked the client to leave the premises immediately. Client claims that he never misrepresented anything, and claims that he brought the designated service animal to all the meetings during the application process. Advocacy Project is assisting BCA with the legal parameters and education about service animals.

Total Referral Calls – 8. ALRP (2); Positive Resource Center (1); Catholic Charities Grievance Procedures (1); St Mary's Grievance Procedures (1); Shanti Grievance Procedures (1); Small Claim Court (1); AHF Grievance Procedures (1).

(Report prepared by Richard Bargetto on 7/31/00)

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July Report
Housing Committee

To:	Members, HIV Health Services Planning Council
Meeting Date:	July 5, 2000
Meeting Place:	25 Van Ness Ave., Room 330-A
Members Present:	Margot Antonetty, Fernando Gomez-Benitez, Catherine Geanuracos, Allen Meyer, and Ali Riker (Chair)
Others Present:	Tom Calvanese, TARC; Carol Carbone, TARC; Chris Callandrillo, CCASF; Elizabeth Colomello, SFRA; Amy Cunninghis, SFAF; Michael DeMayo, Harder +Company; Steven Feeback, minutes; Gail Gilman, Bridge Project; Chris Harris, SFRA; Johanna Keeley, Mayor's Office on Homelessness; Daisy Leyva, DPH (Housing); George O. Simmons, CCASF; and Laura Thomas, DPH-HHS.
Next Meeting:	Wednesday, August 2, 2000, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Mayor's Office on Homelessness

Johanna Keeley passed around a schedule of meetings and a report covering the City's 5-year plan to care for the homeless population. It was written during the years of 1993-'95. The Local Board grows out of recommendations made in the report, and since 1998 is charged with producing an updated plan, called a continuum of care. During the next six months, the Board would like to receive maximum input from wide sectors of the community. She invited everyone to get involved in the process. *Ali Riker* said she wanted to break down any isolation in HIV-related housing issues and make alliances in order to overcome the problems of decreased CARE funding. *Laura Thomas* asked to what extent the HIV/AIDS housing plan had been incorporated into this process, and was assured this would happen. She also requested that the Council's E-mail list be provided to Johanna's office, in order that Council members get further information. Johanna was invited to give a presentation during the next full Council meeting on July 24th. Johanna was asked about Jim Mitulski being rejected as a member of the Local Board and whether or not there was representation from People with AIDS. Johanna responded that the membership of the Local Board was not asked to reveal their HIV serostatus. She talked about mayoral appointments to neighborhood representative's seats, but couldn't really speak to what his decision-making process had been. She mentioned that there was a designated seat for HIV concerns, but there was no preference given to filling that seat with someone who is HIV+. Bob Nelson occupies that designated seat. Tom Calvanese emphasized the need for specific input on a range of HIV-related issues, especially since there is no stated commitment to have representation from that particular affected community. Johanna responded that it would be impossible to have representation from all communities that are affected by homelessness, but the Local Board is able to have representation from many sectors.

Needs Assessment—Report's Housing Information

Michael DeMayo from Harder +Company began this topic by reminding everyone about the two phases of data collection and the resulting analysis reported at a recent Council meeting. He presented another look at the already-released data from the Final Report's Housing Section as well as some additional data. He noted some key patterns emerging. One of these is a possible analysis of a sub-group of respondents: those reporting themselves to be currently homeless (at the time of the survey)

and on the Housing Wait List. He invited further questions or requests for additional analysis, saying that in general the Needs Assessment is about identifying any unmet needs. Michael then delved into the data concerning these homeless respondents. Over half the sample (57%) reported that they had at one time or another been homeless since finding out about their HIV infection. Homelessness was defined as not having permanent or even transitional housing. This included people staying in shelters, in SRO hotels or with friends as well as those on the streets. This is open to what is called interviewer-bias, because this definition of homelessness is something that interviewers took time to explain to respondents. Out of the total sample, 27% said they were homeless at the time of the survey or within the past four months, which was the time frame used for all questions on the survey. The largest racial group among the homeless was African Americans, although this may be slightly influenced by the fact that African Americans were a higher percentage of the sampling than is typical in surveys. It is a population that was actively sought out for participation in the survey. The other over-represented group among the homeless was transgenders. *AR* asked about the calculations of unmet need. Was it true that even the homeless identified areas other than housing as the area of greatest unmet need? Michael raised several issues about how unmet needs were calculated. People had to say there was something they asked to receive and didn't get. The unmet need was then expressed using percentages of those who reported needing a service but not receiving that service. Housing came in third place by this method. *AR* said it was not first even among African Americans or transgenders. Michael said that the survey questions about housing-related services asked if assistance was needed to find a place to stay and if financial assistance for housing was needed. These are the services funded by the CARE Act, but these might not have been the best questions to determine how unmet need for housing services compares with other categories of service, such as dental care or home health care. Then he moved on with his review of statistical analysis.

He said that 59% of people currently homeless and on the Housing Wait List have an AIDS diagnosis. Out of the total sample, about 40% of the respondents said they were on the Wait List. This means that many among the homeless population, even 34 people currently homeless, are not registered with the Housing Wait List. The survey showed that 71% of the people currently homeless and on the Wait List reported needing assistance with finding housing. And, 55% of those seeking such services felt that they got what they asked for, which included emergency vouchers, shelter space, help locating a place to stay, transitional housing, and lastly permanent housing. Of those who received these services, 41% felt they had their needs met, while 10% felt this service didn't meet their needs. This was apparently related to the fact that they were still homeless. Vouchers fulfilled a need for a limited time. It's very difficult to extrapolate these numbers and compare unmet needs in diverse categories. Michael will go back and look at the numbers in a different way. He then went on to further analyze the population that has at one time or another been homeless and is on the Housing Wait List. The survey found that 52% of this group had sought financial assistance in order to deal with a housing crisis, and 38% of the group was served satisfactorily with financial help according to the respondents. They reported receiving emergency vouchers (again), rental assistance, move-in assistance, and one person reported eviction prevention financing. That leaves about 13% who did not get the service they were seeking. About 25% reported that their needs in this area were met, but 7% said their needs were unmet. Many respondents raised complaints about the poor condition of emergency hotel accommodations as well as their waiting time for services. Out of the total sample, about 32% of the respondents said they needed help finding a place to stay. It's unclear what specific services that they sought as a result of their need. Michael felt that the next Needs Assessment should have greater input from the Council's standing committees, such as Housing, so that the survey can be more useful for Housing Services.

Update Re-envisioning AIDS Emergency Housing

Not much new to report, but the RFP is in process. They are hoping for a January, 2001 project startup. There will be more news about the project in the coming months because of the pressing need for emergency and transitional housing units as well as a viable alternative to the vouchers.

The Unfunds Vote

AR did a short re-cap about the vote taken during the past Council meeting. The Housing recommendation to support Eviction Prevention through the work of the AIDS Legal Referral Panel was given second priority. The other project put forward by the Housing Committee received fourth priority, and the available unfunds will probably not be sufficient to do more than the top three.

Housing Wait List Demographics

Amy Cunninghis presented further statistical information. Everyone is examining the demographic profile of who has been referred for housing placement versus the demographic profile of who ultimately gets placement. This needs further study because of all the variables involved.

Housing Contracts Held by Catholic Charities

Chris Harris of the San Francisco Redevelopment Agency presented some preliminary information about commission decisions related to housing contracts held by Catholic Charities. Contracts may get shifted to other agencies, a move that could impact Peter Claver and Leland Houses, perhaps rental subsidies as well.

DRAFT

HIV Health Services Planning Council
Minutes, August 22, 2000

I. Call To Order

SO gave call to order. 4:30 PM

II. Roll Call

Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda

SF corrected that DPH not SFAF would give the Reauthorization Report. Agenda was approved.

IV. Review and Approval of Minutes (VOTE)

SO motioned for acceptance of minutes. *MJW* seconded the motion. Minutes approved by voice vote.

V. General Announcements

No general announcements made. *EW* requested that Council members introduce themselves to new members.

VI. Public Comments

Michael Petrelis, Project Director, AIDS Accountability web site, stated that he has lodged a complaint against Elaine Hanson, of the AIDS Legal Referral Panel with the state of California's Secretary of State. He accuses her of unlawful lobbying, based on comments made in the B.A.R. newspaper. He commented on Council awarding to the AIDS Legal Referral Panel some amount of Ryan White dollars last year for programming in support of legal assistance to PWA/HIV consumers. He also reported that Ryan White dollars went to pediatric care despite very low pediatric cases in San Francisco. He reported that he sent a request to Rep. Coburn requesting an audit of Catholic Charities. He passed out a letter from the GAO to the this Congressional representative regarding dollars allocated to San Francisco versus Los Angeles. A representative from Project Ahead reported that it has not been refunded under Title 4, leaving one agency to serve pediatric and adolescent clients in the city. *SS* reported that Positive Health program is putting together a collaborative project to address the needs of women, children, family and teens in the city. It will apply for funding in 2001. *MJW* reported on the State AIDS Planning Group. She reported that there were no major decisions for this EMA regarding funding at the last meeting; and that the only area of major recommendations would be concerning guidance for PEP (post-exposure prophylaxis) in the case of victims of sexual assault. The State's AIDS Office is writing a guidance draft. *FGB* requested that the Council address the question of support from the CARE Council for the AIDS Legal Referral Panel and their staff member, Elaine Hanson. He considers ALRP an agency doing important work and EH as a very credible AIDS consumer activist. It was thought that the PWA Caucus should address this issue and make a recommendation to the Council. Co-chairs would also seek legal guidance from the City on this item as to whether the members could address this as a full Council.

VII. Reports

Implementation & Evaluation Report

- *SS* reported on the IEC's meeting. She reported on the background of the Congressional Black Caucus dollars in regards to CARE Council efforts. She presented two recommendations from the meeting for Council vote, one for level funding and one for increased funding.

1. Level Funding Scenario – Continue current funding if programs are being delivered as promised according to the monitoring reports from the AIDS Office but awardees would be strongly encouraged to open doors EMA-wide to include residents of San Mateo and Marin Counties;
2. Increased Funding Scenario – Asks the AIDS Office to evaluate the CARE system and identify populations addressing HRSA-mandated needs targets for Case Management, Treatment Advocacy, and Peer Advocacy and directs the AO to formulate a process for addressing the needs identified. There was a brief discussion and question and answer. No dollars are to be set aside for evaluation.

Roll Call vote – first scenario was voted yea unanimous, second scenario was voted yea unanimous (Roll Call Sheet, Col. 2)

Ryan White Reauthorization Process Presentation

- *LT* introduced *Colleen Johnson*, Policy and Planning Officer for the Department of Public Health, who reported on the Ryan White Reauthorization Update. She presented brief facts about the two bills being considered, how they differ and are similar, and how each affects different aspects of Ryan White funding. She reported that Congress is currently in recess and that staff members of the respective branches are meeting together to lay the groundwork for hammering out the differences between the bills. There was some discussion regarding the Ryan White Reauthorization process.

AIDS Office Report

- *LT* passed out the announcement of the updating of the state of need for the city as required by Ryan White. She passed out a memo regarding the amount spent on women, families and children services. It was over 6% of the overall budget. She reported that due to the nature of the report transgendered individuals are not included. She passed out the CARE budget with several caveats, the most important being that this was not the dollar amount that would be awarded but the amount needed to address all the priorities that the Council set. The budget was motioned, and approved (see Roll Call sheet, Column 3). *LT* requested membership forms. She passed out a grant reviewer sign-in sheet so Council members could review the grant before it is submitted.

PWA Caucus

- *JM* reported that there were two meetings in August. He stated that the Tenderloin Forum was tabled until a review of the shared values of the five-year plan was discussed in full. *EW* requested that more members attend the Caucus meetings.

STD/HIV Presentation

- *Jeff Klausner*, presented information on STD and HIV in San Francisco. He passed out guidance from state and city health officials.

Housing Committee Report

- *AR* passed around a copy of the Committee's six-month goals and objectives.

Steering Committee

- *SS* reported on the Five-Year Strategic Plan Working Group. She reported that the group had difficulties forming a core group to consider share values. She stated that the committee sent a copy of their document to the Contractor's Assoc., AIDS Office and the PWA Caucus to review and offer feedback on the relevance of the shared values. *BT* volunteered to collate the comments into the working draft and present to the next meeting. The group will review for missing "voices" and discuss how to include that piece to create a final document of shared values to present to Council.
- *SO* reported that both *EW* and *SS* will not be seeking new terms as Co-Chairs. Nominations would be open until the next Council meeting. *EW* gave consideration for the position. *SO* was nominated and seconded. *VC* was nominated and seconded.

VIII. New Business

No new business was reported.

IX. Adjourn

7:30 PM

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Sept 25, 2000

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes**, 8/28 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *New HIV Incidence and Prevalence (Rate & Figures)* Michael Shriver, Tom Coates and team	**4:55 PM**
	• *HIV Health Services of SF-DPH* Laura Thomas	**5:25 PM**
	• *Department of Public Health* Reauthorization of CARE Act	**5:30 PM**
	• *Transgender Health Conference – Report Back* Bob Teague, MSSW	**5:40 PM**
Break		**6:00 PM**
	• *PWA Caucus*	**6:20 PM**
	• *Implementation & Evaluation Committee*	**6:30 PM**
	• *Membership Committee*	**6:40 PM**
	• *Housing Committee*	**6:50 PM**
	• *Steering Committee* Co-Chair Nominations and Elections – **VOTE** 5-year Plan Working Group	**7:00 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Wed	9/27	Membership Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	10/2	5-year Plan Working Group	25 Van Ness, Room 330	3:00 – 5:00 PM
Mon	10/2	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	10/4	Housing Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	10/4	PWA Caucus	25 Van Ness, Room 330	3:00 – 5:00 PM
Mon	10/9	Indigenous Peoples Day/Steering Comm???	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	10/16	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	10/23	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Mon	10/30	5-year Plan Working Group	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	11/1	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

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Minutes, Sept. 25, 2000 HIV HEALTH SERVICES PLANNING COUNCIL
Draft until approved at future council meeting

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I. Call to Order
4:35 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was revised to show that Laura Thomas would be making the report on Reauthorization of the Ryan White CARE Act by Congress and the Dept. of Public Health would be making a Quarterly Report. Revised agenda was accepted by consensus.

IV. Review and Approval of Minutes
08/28/00 Council Meeting Minutes – A motion to approve the minutes from the August meeting was agreed upon by consensus.

V. General Announcements
Laura Carcagno Guzman announced that honors were being bestowed on two members of the Council by the Positive Resource Center. Selected as "Advocates of the Year" were Janis Takamoto and Carmen Madriz. Both work as Social Workers at S.F. General Hospital. The awards were given in conjunction with the annual fundraising GALA for the Positive Resource Center. Veronika Cauley mentioned that Council member Mike Shriver was recently honored by the Stop AIDS Project for his HIV prevention work, along with other notables such as Carla Clynes.

VI. Public Comment
Hank Wilson announced that Survive AIDS, along with many other community activists have all called for the public to boycott the Medical Marijuana Dispensary run by ACT-UP/San Francisco. There are a number of other options for people with AIDS and other life threatening illnesses. The coalition is providing information to HIV+ people and people with AIDS in order to highlight the damage being done to the community by ACT-UP/San Francisco. Felicia Jones, president and founder of Hope Preservation Inc., is involved in educational work primarily in the African American community of San Mateo County. They are working to get the churches more involved and to train teenage peer educators. Michael Petrelis, from AIDSstatistics.com, passed around a news release including the monthly STD report for San Francisco. He noted that the category for new cases of male rectal gonorrhea had been put back in the report, saying the numbers were up only because higher numbers of people were being tested. He also explained his "ethical qualms" about a "blinded study" of HIV prevalence conducted by the Dept. of Public Health. Dave Pascarelli, from ACT-UP/San Francisco, talked about the group's views, namely that HIV does not cause AIDS, that the antibody test is unreliable and should be banned, that anti-HIV medications are poison, and that money is being squandered on a corrupt AIDS industry. He wished others good luck in efforts to promote a boycott of their Pot Club and claimed that the boycott had only produced greater media coverage of their message. He said that those who buy from them support their message. Ronnie Burk, another member of ACT-UP/San Francisco, delivered a similar presentation. A point of misinformation concerning the Housing Wait List was clarified after he finished speaking.

VII. Reports

VIII. New HIV Incidence and Prevalence Information
Michael Shriver explained that HIV infection rates are up in San Francisco among the gay male population. This conclusion is drawn from studying 25 separate data sets. First, he explained the difference between two means of measuring how much HIV infection is present in any given

population: incidence (a mathematical calculation) and prevalence (actual numbers). By both measures, HIV infection is down among injection drug users as a group and heterosexuals as a group. Incidence rates are up for homosexuals as a group and injection drug users who are homosexual. Michael reviewed all the indicators and presented figures from most of the 25 available data sets. (A member of the public became enraged at the presentation and left the room shouting.) The indicators and the incidence rates were also well summarized in the hand-out that accompanied the presentation *(please see attachments)*. Overall, Michael called for a new, more relevant prevention model for gay and bisexual men. He closed his computer-generated presentation with the 11-point action plan for HIV prevention in San Francisco. Despite official support for this plan, the foreseeable future will see the epidemic in San Francisco produce higher numbers of people living with AIDS or HIV disease, and increasing numbers of them being gay and bisexual men. Greater effort will be needed in order to provide comprehensive care to the rising numbers of people. He cited information about the advisability and cost benefit of trying to eradicate or severely reduce other STDs within populations of people with HIV disease. New strategies are needed in order to have an impact on the estimated 1 out of 10 gay men who have at one time injected drugs; perhaps 25% of them are currently injecting, and this translates to about 1500 men. This number is growing because they tend to recruit new users. There was a quick exchange about harm-reduction strategies, with the point being that targeted techniques for promoting health and reducing risk have to be intensified. He also called for greater effort in the area of mental health services for HIV positive people, including individual counseling. He called for more appropriate, better anti-viral drug regimens and getting people the support needed to maintain adherence. We should be trying harder to reduce the numbers of gay men who continue to inject drugs, through appropriate treatment, while at the same time supporting harm-reduction.

Susan Shea asked Michael his views on how this situation compares to other EMAs across the country and on how to handle HRSA's mandate targeting CARE Act funds to under-served populations. In San Francisco, gay men are one of the more under-served populations, but HRSA apparently does not recognize this type of socio-demographic analysis as having an impact on their formulation of under-served categories, even if only in some EMAs. This is clearly a reprise of earlier days in the epidemic when it was difficult to get federal attention or funding for AIDS care because it was viewed as hitting primarily in the gay male community. Now San Francisco's amount of funding is getting cut because its epidemic does not conform to the East Coast demographic profile and therefore gets interpreted by homophobic sectors as a case of too many over-served people sustaining a bloated service system. There is an injection drug related component to the epidemic in San Francisco, but unlike other cities, it is among gay men and there is little effort to target injectors who are gay men because they are not shooting heroin, which is the focus of treatment programs nationwide. One out of five or 20% of the men in San Francisco are gay men (approximately 52,000 and growing). But, incidence rates are not a function of the total size of any given population. Rather, these are infections that were not anticipated and a high incidence rate is calculated in that way. The web site featuring this material is *hivinsite.ucsf.edu* and it is also available on the DPH site.

IX. HIV Health Services of DPH

Laura Thomas passed out copies of the SF-EMA's FY2001 application for grant funds under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act (dated Sept. 20, 2000). She presented some of the highlights, noting that HRSA asked repeatedly that the application indicate to what extent the HIV Health Services Planning Council is identifying people who are newly infected and communities where HIV prevalence is increasing. The communities being hit the hardest now with increasing prevalence of HIV infection are the communities that have been hit the hardest all along. She invited members of the Council to provide suggestions and feedback about the application. She explained why the administrative

budget is not included in the copies for distribution and *SS* reminded members that the Council reviewed the administrative budget approximately six months ago. Laura also did a quick update about the ongoing efforts in Congress to reauthorize the Ryan White CARE Act. It's coming to the very final stage of a lengthy process. Annual cuts to SF are anticipated during the 5-year life of this bill. She estimated that the cuts would be in the neighborhood of $7,500,000 over that period. However, such estimates are imprecise because both the formula grant and the supplemental grant are affected, but in ways to be determined.

Michele Long Dixon passed around a written "2nd Quarterly Report to the HIV Health Services Planning Council." The second quarter of this contract year includes the months of June, July and August. She gave the current contract status report, saying that 85 CARE contracts and MOUs were in various stages of development and processing: 65 were already certified, 3 were in the process of certification, and 17 were in the review/negotiation phase. She said that most of the CBO contracts had been certified and were being paid. The bulk of contracts remaining were departmental entities associated with DPH. Next, she said that there were some Carry-forward funds from the CARE Title I 1999-2000 grant, and these totaled $643,625. HRSA approved our request concerning utilization of carry-forward funds, including about $70,447 to be divided among three priority projects identified by the Council. One of those is a CBO project, the Eviction Prevention efforts in our Housing category. Negotiations will soon get underway for the augmentation of a contract to accomplish this work. An RFP has been issued to deal with the third priority project related to food and household goods vouchers. Next, she reported that the Annual Program Monitoring activities are starting with training and orientation. She also mentioned the appointment of Jimmy Loyce as Director of the AIDS Office. Finally, she acknowledged how great it has been working with the two out-going Council Co-chairs.

X. Presentation—Transgender Care Conference Report Back

Bob Teague reminded the membership that this conference took place back in May 2000. His work at the AETC involves HRSA-mandated training, mostly for primary care providers. He introduced his partner in this presentation, Dr. Stacy Hart, and acknowledged two members of the Council who helped with the planning, Cecilia Chung and Veronika Cauley. He started with a historical review about the development and planning process. Conference planning only took about five months. Most of the people attending the Conference were involved in primary health care or direct services. It had the limitation of being a one-day conference, and there was probably too much information and useful material crammed into a single day. Stacy took over the presentation and began by introducing herself. She is the new Project Evaluator with AETC and comes from a background as a Research Psychologist. She distributed copies of a Conference Evaluation Summary based on participant responses to five open-ended questions. There were many very positive outcomes. She would like to follow-up with a post-conference survey in order to see whether or not actual changes have taken place as a result of what was learned at the conference. She would like to get a sense of what the participants have done with the training and what are the remaining gaps? Laura Thomas added a comment reflecting on the controversy of this being a conference focused on HIV care. This Council supported the conference with the view that the content would comprise an HIV-based training that would fill a void concerning primary care for Transgenders. Most medical care providers completely lack any type of training related to Transgender health. This larger problem made it difficult to focus primarily on a single health issue, HIV.

XI. PWA Caucus

Jim Mitulski recognized Veronika Cauley for her service as Caucus Co-chair, and reported that the newly elected replacement would be Gary Harrell. The PWA Caucus took two meetings for discussions of "Shared Values" in order to contribute to the 5-year strategic

planning process. *MS* announced that the set of commercials in an ad campaign targeting HIV+ people—HIV Stops With Me—will begin running on primetime TV during the next few weeks.

XII. Implementation & Evaluation Committee

Gene Gowdey gave a report concerning progress the committee has made in analyzing the accomplishment of tasks related to the set of two-year priorities set by the Council. DPH's HIV Health Services and the various Council committees are making a series of presentations to the committee regarding the up-to-the-minute status of implementation efforts. After each priority area has been heard from and this work completed, the committee will move on to analysis of the reauthorized Ryan White CARE Act in order to determine any impact on the Council's process and procedures. In addition, he called for continued attention on the part of the Council and DPH to the contract certification process. He expressed continuing concerns about the length of time that it takes. A Task Force will be constituted for the purposes of examining the category of Case Management Services.

XIII. Membership Committee

Laura Guzman said that the committee had not met in a couple of months and reminded the Council that there is a very small number of active members on the committee, at times not enough to conduct official business. She anticipates that there will be an increase in the number of applicants for the Council as the time approaches to decide on programmatic priorities in conjunction with cuts in funding. She asked for additional participation in the Membership Committee. There is also a need for another round of orientation and training in order to bring new members up to speed.

XIV. Housing Committee

Ali Riker said the committee had examined its goals and objectives, which have been distributed to the Council in written form. The committee has also spent a great deal of time on the priorities related to improving the Emergency Housing Voucher system and the quality of emergency housing for clients. A full discussion of this topic will be scheduled for next Council meeting, and it was acknowledged that an extensive outreach/education effort would be needed in order to explain the changes to clients. *LCG* brought up concerns about the housing voucher changes that had been heard from some clients, and there will be a further opportunity to discuss these concerns at the next committee meeting. *MA* explained some background on the work accomplished by a Task Force and the need to combine the dollars dedicated to housing vouchers with other financial sources in order to create a new system for providing temporary, transitional and medical respite housing instead of vouchers for SRO rooms. *SS* commented that there are some gaps in communication about the implementation of priorities. The Housing Committee has taken on the implementation tasks regarding the priorities that are housing-based, but it is the I&E Committee that is charged with overall oversight of the process of carrying out our programmatic priorities. In general, there has been some lack of communication back to the full Council about the follow-through tasks associated with various priorities and what has resulted from these tasks.

XV. Steering Committee

Eric Whitney said that nominations for the Co-Chair positions of the Council are open up until they are officially closed. All three positions are up for election. He reminded members that there are three specific criteria that must be met by some combination of people among the three who are selected: a woman, a person of color and an openly HIV+ person. Those three characteristics can be embodied in one, two or three people. He called for further nominations. Eric then nominated Laura Carcagno Guzman, she accepted and her nomination was seconded. *EW* said three people had been placed on the ballot thus far,

including the two from last meeting—Veronika Cauley and Stephan Oxendine. Next, Council member Jim Mitulski was nominated; he accepted the nomination and received a second. *EW* asked for further nominations, but none were announced. It was moved and seconded to close the nominations. *EW* brought up some of the rules again. Voting is a matter of public record and members must write their name of the ballot. Members don't have to vote for anyone, can vote for 1-3 people, and for no more than 3. The four nominees talked about their characteristics and two of them chose to disclose their HIV+ status. Each one offered a short statement about their participation in the Council and the skills they bring to the task of Co-chair.

Ballots were distributed and several minutes were taken to fill them out. *SS* and *EW* gave quick remarks about their feelings upon relinquishing their roles as co-chairs. In Eric's case, he is also leaving the Council and he took a moment to express his appreciation to the Council. Susan will continue as a member of the Council.

While the balloting was tabulated, *SS* gave a quick update about the work of the Long Range Planning Task Force. She said it's running a little bit behind schedule. A first draft of the document is in development, and there will be further stages of review and input. *SK* brought up the difficulties caused by the long-range planning group being over-represented by service providers and administrators. He feels the consumer side is under-represented. *SS* responded that the PWA Caucus is viewed as our collective voice for clients or consumers of service. She hopes the caucus will also help identify other sectors to be consulted for this process.

XVI. New Business

MS called for a presentation of HRSA's data on the access to and utilization of AIDS drugs by source of funding: specifically ADAP and Medicaid. He would like it to be scheduled in a future meeting. *KW* expressed appreciation for the way in which each meeting has had a relevant presentation and a chance for questions, discussion and thought about the issue. *EW* spoke about his new position as Computer Training Coordinator; it entails tech training and marketable skills with which clients can prepare to re-enter the workforce.

EW announced and congratulated the three newly-elected Co-chairs: Stephan Oxendine, Laura Guzman, and Jim Mitulski.

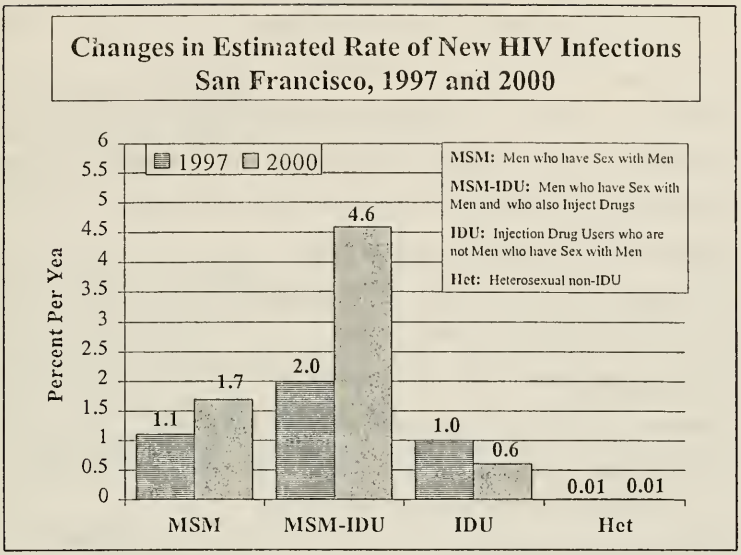
XVII. Adjournment

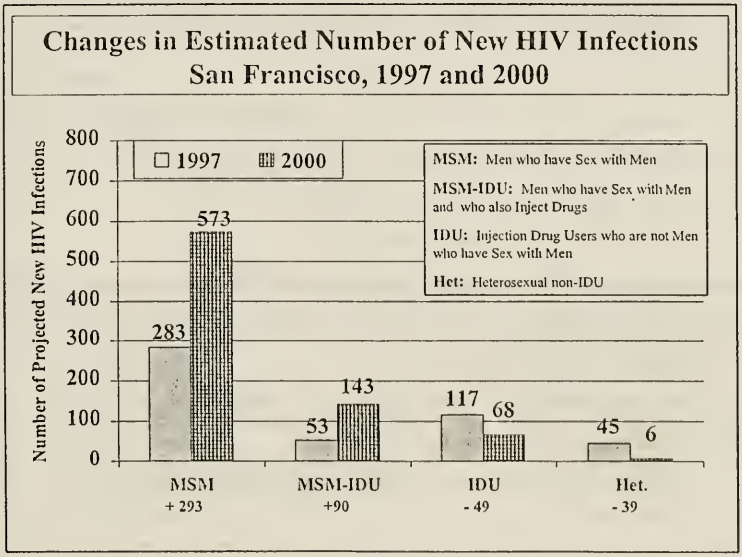
HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

September 25, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Hazel Betsey	*HB*	P									
3. Jeff Byers	*JB*	P									
4. Bart Casimir	*BC*	P									
5. Veronika Cauley	*VC*	P									
6. Raymond Combs	*RC*										
7. John Conley	*JC*										
8. Cecilia Chung	*CC*	P									
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*	P									
11. Catherine Geanuracos	*CG*	P									
12. Fernando Gomez-Benitez	*FGB*	P									
13. Gene Gowdey	*GG*	P									
14. Laura Carcagno Guzmán	*LCG*	P									
15. Gary Harrell	*GH*	P									
16. Brad Hume	*BH*	P									
17. Sam Kaplan	*SK*	P									
18. Jeffrey Klausner	*JK*										
19. Gene London	*GL*	P									
20. Carmen Madríz	*CM*	P									
21. Michael Meehan	*MM*	P									
22. Allen Meyer	*AM*	P									
23. Jim Mitulski	*JM*	P									
24. Gregory Neumark	*GN*										
25. Jorge Ortíz	*JO*										
26. Stephan Oxendine	*SO*	P									
27. Ken Pearce	*KP*	P									
28. Alissa Riker	*AR*	P									
29. Susan Shea	*SS*	P									
30. Mike Shriver	*MS*	P									
31. Janice Takamoto	*JT*	P									
32. Bob Teague	*BT*	P									
33. Kelly Wallace	*KW*	P									
34. Robert Whitford	*RW*										
35. Eric Whitney	*EW*	P									
36. Mary Jane Wood	*MJW*										

Attachment B-1





San Francisco HIV Prevention Indicators

- ↑ Incidence of HIV among a cohort study of Young MSM
- ↑ Incidence of HIV among MSM seeking anonymous HIV testing
- ↑ Incidence of HIV among MSM-IDU seeking HIV testing
- ↔ Stable, high HIV incidence in MSM seeking STD treatment
- ↑ Reports of rectal gonorrhea among MSM
- ↑ Frequency of STDs among MSM living with AIDS
- ↑ Number of MSM living with AIDS
- ↓ Consistent condom use among MSM
- ↑ Multiple partners and unprotected anal sex among MSM
- ↑ MSM engaging in unprotected anal sex with serodiscordant partners and/or with partners of unknown HIV status

Summary of HIV Indicator trends among MSM in San Francisco

- ↑ Incidence of HIV in a cohort of MSM
- ↑ Incidence of HIV among MSM seeking anonymous HIV testing
- ↑ Incidence of HIV among MSM-IDU seeking HIV testing
- ↔ Stable, high HIV incidence in MSM seeking STD treatment
- ↑ Reports of rectal gonorrhea among MSM
- ↑ Frequency of STDs among MSM living with AIDS
- ↑ Number of MSM living with AIDS at year-end
- ↓ Constant condom use among MSM
- ↑ Multiple partners and unprotected anal sex among MSM
- ↑ MSM engaging in unprotected anal sex with serodiscordant partners and/or with partners of unknown status

DRAFT

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Oct. 23, 2000 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 9/25 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *HIV Health Services of SF-DPH*	**4:55 PM**
	The AIDS Office and other matters	
	• *Department of Public Health*	**5:10 PM**
	Ryan White CARE Act Reauthorized	
	• *Statewide Coordinated Statement of Need*	**5:15 PM**
	Taking a new look at this document	
Break		**6:00 PM**
	• *Housing Committee*	**6:20 PM**
	Emergency Housing Update	
	• *PWA Caucus*	**6:40 PM**
	Tenderloin Community Forum	
	• *Membership Committee*	**6:50 PM**
	• *Implementation & Evaluation Committee*	**7:00 PM**
	• *Steering Committee*	**7:10 PM**
	December Schedule of Meetings	
	5-year Plan Working Group	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type	Location	Time
Mon	10/30	5-year Plan Working Group	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	11/1	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	11/1	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Thurs	11/2	Membership Committee	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	11/6	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	11/13	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	11/20	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	11/27	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	11/29	???????or Wed. 12/6	25 Van Ness, Room 330	3:00 – 5:00 PM

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, call the Council's staff at 415-863-8131. The closest accessible BART station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #5 Fulton, #21 Hayes, #6, 7, 71 Haight/Noriega, #9 San Bruno, F-Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 415-923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

MEMO

DATE: October 10, 2000
TO: HIV Health Services Planning Council
FROM: Laura Thomas
Health Planner
RE: Statewide Coordinated Statement of Need

The Statewide Coordinated Statement of Need (SCSN) is a document that is mandated in the Ryan White CARE Act, and is designed to incorporate needs and service goals for people with HIV/AIDS throughout the state. California is in the process of preparing its second SCSN, which will be completed by March 2001. We have been asked to fill out a questionnaire as the Title I grantee, and we want to incorporate input from the Planning Council. In particular, we would like your input on current and emerging HIV/AIDS service and care needs and goals for HIV/AIDS service and care.

In preparation for the Council meeting on the 23rd, please think about what you consider the most important **current issues** and **new and emerging issues**. Examples from the prior SCSN are: housing, case management, poverty, correctional/prison issues, managed care, primary medical care, substance abuse treatment, young people, women's health, cultural issues, drug therapies, employment development, HIV reporting, multiply-diagnosed populations, oral health, transportation, welfare and immigration reform, and mental health. We are not limited to the old list, but it is a useful place to start. For the new issues, please think of any new issues that affect the delivery of services in the EMA or for specific populations (e.g adherence, hepatitis C).

I have attached the list of service goals from the last SCSN. Please review it before the meeting, and think about any additional significant broad goals that you think should be added or rewritten. Again, we are not limited by this list, but it is a useful place to start, and gives you a sense of what they should look like. The State wants us to limit this list to only the most significant goals.

In addition, the questionnaire asks for a summary of the most recent needs assessment and some epidemiological information. I will complete both those sections. The questionnaire is due on October 31st. Grantees of other Titles have also been asked to provide input, and the State is holding consumer forums around California.

STATEWIDE COORDINATED STATEMENT OF NEED SERVICE GOALS
MARCH 1998

The following is a **non-prioritized** series of broad proposed goals for HIV/AIDS services and care in California over the coming months and years, based on findings that have a broad consensus among HIV providers and persons living with HIV throughout the state:

Overarching Care and Service Goals:

- Ensure that all persons living with HIV in California receive all services necessary to sustain and support their health and quality of life, regardless of income or ability to pay, and across all stages of illness.

- Ensure that HIV/AIDS services in California are delivered in an equitable, client-centered manner, and that services respond sensitively and appropriately to client age, gender, cultural group, primary language, sexual orientation, income, region of residence, family status, health status, incarceration status, and legal residency status.

- Ensure and protect the confidentiality of all persons with HIV and AIDS in California, particularly as reporting requirements related to HIV and AIDS diagnosis may change in the future.

- Expand the participation of persons living with HIV at all levels of HIV/AIDS planning, needs assessment, systems design, service implementation, and evaluation in California, and enhance opportunities and incentives for this participation. Ensure the participation of members of specific populations - such as women, young people, and people of color - in the development of services specifically geared to these populations.

- Maintain and enhance an effective system of care for men and women living with HIV/AIDS by sustaining and strengthening California's community-based system of HIV/AIDS care in spite of the many changes now confronting the United States health and social service system. This goal is vital not only because of the quality and scope of support that the system offers to people with HIV in California, but because the system provides a model for the provision of community-based care in other health and social service areas. To assure equitable and quality care for all needy Californians, efforts must be made to raise the response to other social issues and diseases **up** to level of HIV/AIDS, and not **down** to a lower common denominator in which none receive the proper levels of community-based care, support, advocacy, and assistance that they need and deserve.

- Support the continuation of locally based HIV/AIDS planning with the widest possible scope of Health Resources and Services Administration (HRSA)-eligible

service categories available to local jurisdictions and agencies. Each HRSA category fills a valid unmet need somewhere in the state's service delivery system and should be maintained in the continuum of care for the state.

Case Management:

- Improve the quality of service access and coordination for persons living with HIV/AIDS by increasing the professionalism, relevance, comprehensiveness, and client sensitivity of case management services at all levels of care, and by expanding efforts to create and support integrated case management systems and definitions throughout California. This includes reorienting case management in relation to new drug therapies; expanding case manager training and education; recruiting greater numbers of self-disclosing HIV-positive case managers; reducing unreasonable client caseloads; and facilitating greater integration and consolidation of regional case management systems among social and medical service agencies.

Corrections Settings and Incarcerated Individuals:

- Expand the participation of care providers from the corrections system in HIV planning bodies in California, and ensure full access to combination therapies and compliance support in correctional settings.

Drug Therapies and Emerging Combination Treatments:

- Ensure the universal availability and subsidization of all appropriate new and existing medications and drug treatment combinations for all eligible persons with HIV who wish to receive them.

- Expand the number of candidates for combination therapy through relevant services such as substance abuse treatment, housing, transportation, and case finding, and provide services to support patient adherence at all levels.

- Ensure continuing professional competence in prescribing and monitoring medications for persons living with HIV/AIDS and in supporting patient adherence through mandatory continuing education, professional training, and the development and dissemination of continually updated clinical standards.

Housing Services:

- Ensure that persons with HIV/AIDS - including families affected by HIV - are able to access a comprehensive continuum of housing services and resources, including emergency shelter, transitional housing, housing/rental subsidies, foster homes, congregate living facilities, skilled nursing facilities, board and care facilities, transitional housing for parolees and others released from prisons and detention facilities, and housing for people with multiple diagnoses. Ensure that

HIV/AIDS housing is available in the least restrictive form desired by each individual. Develop strategies and technical assistance resources to help communities access additional housing resources for persons with HIV/AIDS. Encourage and provide incentives for local jurisdictions to utilize Community Development Block Grant funding, Department of Housing and Urban Development funding, and other housing funds as sources for building or converting low-income housing specifically for persons with HIV/AIDS.

Managed Care:

- As private managed care providers are given more responsibility for caring for Medicaid beneficiaries, and as the prevalence of managed care systems in California expands, ensure that people with HIV/AIDS who are enrolled in these systems have access to the leading standards of care for HIV disease. Require that managed care organizations provide geographically accessible, specialized, and qualified HIV/AIDS services and providers for all persons with HIV. Require that a clearly understood and easily accessible consumer grievance system is in place in all managed care programs. Adjust managed care capitation rates or create "carve-outs" where needed to reflect the full range and frequently higher costs of service provision for persons with HIV/AIDS. Ensure an adequate Medi-Cal capitation rate that includes drug treatment, outpatient medical and dental care, social services, and risk of inpatient care.

Multiple-Diagnosed Populations:

- Ensure the development and implementation of a comprehensive system for addressing the needs of multiple-diagnosed populations in California-particularly individuals affected by HIV and by mental health and substance addiction. Assure that the complex needs of these individuals are addressed so that they do not "slip through the cracks" as health systems focus more closely on cost-efficiency and cost savings in light of managed care. Explore the possibility of integrated funding to support these services within a unified framework.

Primary Medical Care:

- Ensure that comprehensive primary medical care services are accessible and affordable for all persons living with HIV/AIDS in California, regardless of changes in the nature and scope of the HIV-affected population, or of changes in medical diagnosis and treatment techniques now or in the future.

Poverty as a Public Health Issue:

- Address the fact that a growing percentage of HIV-related client needs and problems are rooted in poverty by developing effective methods to jointly address poverty and HIV issues in California. Increase opportunities to form and develop

partnerships between HIV providers and poverty-related community groups and residents in order to expand and deliver services for both populations.

Research and Clinical Trials

- Include the broadest possible cross-section of populations affected by HIV/AIDS - including minority populations, adolescents and young adults, women, and injection drug users - in government-sponsored clinical trials programs, and expand the opportunities for persons with HIV from all economic, geographic, and cultural backgrounds to participate in clinical trials research. Support research on complementary and alternative therapies as an important strategy for exploring potentially promising new treatments for HIV disease. Continue and expand support for research into models of service delivery, models of evaluating effectiveness and efficiency in care delivery, client adherence to care appointments and therapeutic regimens, and the importance of cultural responsiveness in improving client adherence

Rural Issues:

- Address continuing HIV/AIDS service deficiencies and barriers in rural areas, including lack of transportation, lack of skilled service providers, and a shortage of doctors, nurses, and health care professionals qualified and trained in HIV care.

Service Integration and Coordination:

- Enhance the quality, scope, and coordination of care for persons living with HIV/AIDS in California by increasing the ability of providers to plan and develop collaborative, multi-disciplinary approaches to HIV service and care, especially in light of the changing, complex needs of those affected by the epidemic. Develop opportunities and incentives for increased interaction and service integration among providers and consumers, CARE Act grantees, HIV/AIDS and non-HIV/AIDS-specific agencies, local and regional health jurisdictions, medical and psychosocial providers, public and private funders, private and government bodies, local and national agencies, rural and urban providers, and local and regional consortia and planning groups.

Substance Abuse Treatment and Recovery:

- Ensure the availability of substance abuse treatment programs for all persons with HIV/AIDS who wish to receive them, through a continuum of treatment options including detoxification, short-term and long-term residential care, and outpatient services. Ensure the availability of supportive services that help individuals achieve success in substance abuse, including transitional and supportive housing for individuals leaving treatment, transportation, mental health services, and job training and placement.

The Changing HIV-Affected Population:

- Examine the ways in which the existing system of HIV service and support will need to change or become more flexible to address those HIV-affected populations that are most frequently affected, including HIV-affected women and single mothers, people of color, low-income individuals and families, injection drug users, young people, people in correctional settings, and residents of rural and frontier communities.

- Examine the ways in which the HIV service system will need to evolve to confront the fact that many men and women HIV and AIDS are living longer, and are requiring a distinct set of services - including long-term housing, vocational rehabilitation, job placement, client education, insurance assistance, benefits advocacy, policy research, financial planning, and secondary prevention support - which is oriented toward helping them live long, productive, and self-sufficient lives. Address the fact that the growing perception of HIV disease as a chronic, non-life-threatening illness is affecting both the availability of resources and the ability to sustain existing systems of care.

Tuberculosis Control:

- Recommend HIV counseling and testing for all persons with confirmed, suspected, or contact tuberculosis in California.

Women's HIV Services:

- Address the special and growing needs and problems of HIV-infected women and single mothers in California, including the need for expanded prenatal care and voluntary prenatal HIV testing to prevent perinatal transmission; increased child care and respite care resources; the potential adverse effects on women of welfare reform; the lack of competent medical advice regarding combination therapies; and the need for increased participation by women in clinical trials.

- Ensure that all California pregnant women have early access to HIV diagnosis and treatment - including the use of Zidovudine (AZT) - along with strong protections of personal confidentiality and choice. Advocate for updated prenatal guidelines for pregnant women who may be living with HIV.

Minutes, Oct. 23, 2000 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

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I. Call to Order
4:35 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present at that time, but late arriving members would result in a quorum. This means that the meeting could proceed without voting until a quorum is present.

III. Review and Approval of Agenda
Co-chair *Jim Mitulski* noted that the Housing Committee would give its presentation as scheduled after the break because Ali Riker and Marc Trotz would be arriving by that time. This agenda was accepted by consensus.

IV. Review of Minutes
09/25/00 Council Meeting Minutes – *Sam Kaplan* called for a correction concerning the definitions of HIV incidence (new cases) and HIV prevalence (all cases) on page two of the 09/25 Minutes. Also a correction was made in spelling of a name. A quorum of the membership still had not arrived, thus delaying approval of the minutes.

V. General Announcements
Veronika Cauley announced that council member Cecilia Chung had been elected President of the SF L/G/B/T Pride Celebration. She noted some progress on the part of Transgenders in community-wide participation and leadership. She expressed what she considers to be a lack of progress in that regard for this Council over the course of her three years as a member. She highlighted the Co-chair elections that took place two years ago and characterized the situation as one of voting irregularities, thereby preventing her election to one of the three co-chair positions. She also noted the progress toward providing better conditions for Transgender prisoners in the SF jail. *Bob Teague* announced that his office would be sending out the post-conference evaluation surveys in order to gather more information about the results of the Transgender Health Conference. The AETC has scheduled another training on Medical Management of HIV and Substance Use. It will be held Nov. 30, 2000 at UCSF/Laurel Heights. He also noted that the San Francisco AETC was awarded a new grant from HRSA for Training and Technical Assistance, with a delineated line item, thus allowing them to do more one-on-one consultation with service providers. He also acknowledged the Positive Resource Center, which found qualified candidates, one of whom was hired for their administrative opening.

VI. Approval of Minutes
With a quorum of the membership having arrived, a motion was made to approve the minutes from the prior Council meeting (Sept. 25). Motion was seconded, and it passed by consensus.

VII. Public Comment
Hank Wilson first said that he had attended the same Council meeting to which Veronika was referring in regards to co-chair elections, and his recollection was considerably different from what she had just presented. He felt this was necessary to say for the record. On another topic he reported the results of a recent meeting he attended. It was a meeting of Positive Force, a project that attempts to unite people with HIV and AIDS. He said that a common theme among the 30 or so participants at the meeting was a desire to have greater communication with each other and more opportunities to socialize with each other. He characterized this as a common denominator or a shared desire, regardless of differences in age, ethnicity, or race. This same finding arose from the Needs Assessment conducted by this council last year. He said that people want more social interaction. He

said that HIV+ individuals want to help each other and need a social environment for that interaction. The next speaker was Beth Colomello of the SF Redevelopment Agency. She reported that the SFRA had been awarded a grant as a Special Project of National Significance by HOPWA ($1.37 million) in order to extend and expand their current project serving people living with AIDS. A component is specifically designed to counter homelessness among this population.

VIII. Reports

IX. HIV Health Services of DPH

Laura Thomas began this report by saying the Ryan White Comprehensive AIDS Resources Emergency Act had been reauthorized by both houses of Congress and had been signed by the President a few days prior to our meeting. Thus, there is a continuing life of five years for this federal funding. She acknowledged several members of Congress and others who were instrumental in making this happen, despite the inclusion of funding formulas that are not favorable to our EMA. However, there were forces that wanted to see an even less favorable outcome. She plans to prepare a full report for the next meeting in order to analyze sections of the bill and provide detail about any changes that impact this Council.

The Statewide Coordinated Statement of Need was the next topic of discussion. It is a document prepared at the state level; it is required to be re-done every three years under terms of the Ryan White CARE Act. Grantees receiving funds under any of the Titles are required to participate in the process of updating this collaborative statewide plan. California has gotten its process underway by sending a survey sent to all grantees. The SF Dept. of Public Health, as a Title I grantee, wants to respond to the survey after getting input from the CARE Council. Laura asked the Council to focus on "Current/New & Emerging Service Needs" and the overall set of service goals for the future. The SF-DPH will provide a copy of recent Needs Assessments and some relevant epidemiological data. The survey has to be sent back by October 31, 2000. She invited members to "brainstorm" about the issues to be included in the survey response.

Members brought forward the following issues: job training, re-integration into the workforce, medical management of chemical substance use, privacy, displacement in housing, evictions, mental health stress as a result of housing problems, maintaining housing during the transition back to work, prevention for positives, medical providers capacity to deal with sexuality, prostitution, barriers to access for women & transgenders, hepatitis C, healthcare in prisons, access to care for released prisoners, homelessness among HIV+ individuals, and AIDS medicine interruptions.

Michele Long Dixon introduced Jimmy Loyce, new Director of the AIDS Office. He began by describing the reorganization that is symbolized by this position being filled. He reports directly to Mitch Katz, as in the old days of the AIDS Office, and joins two other deputy directors in the health department. He then broke down the section chiefs in addition to Michele Long Dixon of HIV Health Services (Prevention, Research, Epi Evaluation, Field Epi Surveillance, and Support/Fiscal) that report to him. He talked about the transition from his old job, also at the Public Health Dept. and moving his physical office location. He summarized his background and experience with AIDS services. Due to his prior work at the State and the National levels, he indicated that he thought he could carry out some effective advocacy and policy efforts on behalf of the local AIDS response. He is likely to be the lead spokesperson on AIDS issues as related to policy (as opposed to science) from the Dept. of Public Health. He was asked if he had given any thought to changing the name of the AIDS Office. He answered that he was open to change in that regard, but had not given it any thought to this point. With no further questions, Jimmy Loyce said that his phone number for the next few weeks (until moving) is 554-2620.

XI. PWA Caucus

Gary Harrell presented a brief overview of topics discussed. He mentioned the policy on stipends and reimbursements, which remains a not-completely-settled issue. Then he reported on the PWA Caucus's desire to work with members of other committees in order to plan a lively educational theme for the next community forum in the Tenderloin. *Cecilia Chung*, newly elected co-chair of the caucus, added that she considered the bottom-line issue to be: what are we doing as a council to empower potential leaders (with HIV and AIDS) to come forward and take on more active roles and participate more fully in the Council's workload? She supported the view that stipends do provide an incentive to continue participating in long meetings and are seen as a gesture that PWA input is a valued component of the Council's process. She said that the other issue the members want greater clarity on is in the area of housing: how is the master leasing of SRO hotel rooms and other new buildings going to produce better results that the emergency housing vouchers. Then questions came forth about the specifics of the policy on stipends and reimbursements. *JM* said that the Admin. Coordinator had been asked to turn in to the Contractor any members' requests that are pending in order to trigger some clarification of what the current procedure is. Michele Long Dixon asked to speak to this point. She said that HRSA very rarely sends out written policy statements, preferring to leave things ambiguous until they see something they consider wrong. Then they do an audit. This, however, is a case where they put something in writing to say that they are looking only for reimbursable expenses. This is HRSA's policy, while other councils have other funding sources that may do things differently. She said that it would be the Contractor, Positive Resource Center, which would be at risk if they do not adhere to the written policy of HRSA and if they allow members to receive stipends. That agency would be at risk if audited. She invited members to write to HRSA. She added that she thought HRSA's policy was already in place at the time this Council approved its stipend policy. *GH* countered that the PWA Caucus also wanted to gather other views about the legalities of the matter and the history of how this developed. *JM* said that incentives are valuable to promote PWA participation in the Council. It may not be legal. It may not be possible. But, it should be noted that in our view incentives are valuable in gaining greater participation. *CC* spoke to the need to hold HRSA accountable for this policy. She wants to see something offered in the way of incentives in order to encourage participants to come forward from the community.

XII. Membership Committee

JM noted the date and time of the next committee meeting. *Ken Pearce* invited the participation of new people and said the meeting time could shift according the needs of a new group. *Brad Hume* complained about the lack of new member orientation. In fact, he has yet to receive any of the essential documents related to the Council since his appointment in July. He has been attending meetings for about six months now, but feels that his interest is waning as a result of the poor follow-through with regard to supporting new members. *CC* said she, too, would appreciate some type of mentoring and orientation in her role as another of the new members. She urged the experienced Council members to share more of their information with new people. Laura Thomas offered to send out copies of HRSA manuals and other relevant documents from recent history. She encouraged more participation in the Membership Committee in order to help set the agenda for trainings and orientation sessions, among other things.

XIII. Implementation & Evaluation Committee

Gene Gowdey said that they had spent three of their recent meetings on an update and analysis related to the status (achieved, deleted or in progress) for each of the original 2000-2001 Priorities. They heard presentations from the Dept. of Public Health, HIV Health Services concerning five sub-categories. There have been many challenges with regard to implementation. Next, the committee will focus on a discussion about what are the core

services and any "hold-harmless" agreements to be considered. They are seeking input from the network of service providers as well as from consumers of services. They hope to schedule a vote at the next Council meeting.

XIV. Steering Committee

JM asked members to consider the schedule of meetings to take place during December. He presented two options: canceling the Council meeting at holiday time (the 4th Monday is Dec. 25th) or advancing some of the committee meetings by one week so that the Council meeting could take place a week earlier. Pros and cons were voiced by several members. A straw poll was taken, with the majority clearly favoring a monthly Council meeting in December, which would fall on the third Monday, the 18th. Subsequently, a motion was approved by consensus. The last meeting of the Long Range Planning Committee fell short have having sufficient numbers of people to conduct the committee's work.

XV. Housing Committee

Hazel Betsey said the committee wanted to present information to the Council about the change that is planned in emergency housing and is scheduled for implementation by DPH during the upcoming year. Emergency Housing is a sub-category of the Priorities related to the use of Emergency Housing Vouchers in SRO hotels that are provided to clients under a program operated by the San Francisco AIDS Foundation. The availability of these vouchers has fluctuated from year to year, depending on amounts of "Unfunds" added to the category. Most recently, clients have been eligible for up to four weeks, but there have been years in which funds added at the close of the fiscal year brought some clients up to 12 weeks. *Fernando Gomez-Benitez* added information drawn from the Council's Needs Assessment conducted about a year ago. The question was about the vouchers and were they meeting client's needs. People answered that the 28-day rule meant too little time for them. And many expressed their feelings about how bad the conditions are in some of the SRO hotels (infested with rats, roaches and drugs). There were a wide variety of complaints about other housing programs, such as the Housing Wait List and the subsidies, but a high percentage were related to the program that places people in poorly maintained units for short periods of emergency housing. *Catherine Geanuracos* talked about how the current proposal relates to prioritization, given the high level of unmet need identified. She said the general lack of capacity to house people with HIV and AIDS in all stages of medical condition and the poor quality of emergency housing prompted the Council to prioritize changes to the voucher system. The objective is to remove a major barrier to healthcare. The three Council Priorities related to this are: to improve integration of all housing assistance funds, to expand decentralized points of access to emergency housing, and to block out groups of rooms in one hotel (rather than scattered site). She expressed her view that these three things are well addressed by the plan that has been developed by a Task Force, by the Housing Committee and by DPH-Housing Services. This proposal definitely conforms to the spirit of the Council's discussions about the conditions in SRO hotels and the availability of housing (emergency, transitional and longer term).

Next, *Ali Riker* talked about how the Housing Committee had the task of implementing these three Priorities as well as others in the area of housing. The Re-envisioning AIDS Emergency Housing Task Force had good representation and took six months for fairly extensive work. Key Points are as follows:

1) Not enough people were gaining longer term stability under the emergency voucher system;
2) Conditions in some SRO hotels utilized by the system are less than ideal;
3) Emergency voucher hotels are continually violating the law to prevent clients from gaining tenancy;
4) The vouchers are assisting people in a wide range of medical conditions; and
5) There is a trade-off, by necessity, between serving more people for a short period of time with shelter on one hand and serving correspondingly a lower number of people for longer periods of time with more substantial services on the other hand.

She said that after a full discussion of this topic at the last meeting of the Housing Committee, members who were present voted 7-0 in support of this plan. Then she introduced the Director of Housing Services for the Dept. of Public Health, Marc Trotz.

Marc began by passing around a chart in draft form, showing the proposed housing. He said that the overall desire is to make the funds spent on emergency housing more effective. This can be accomplished by directing resources into housing that is higher quality, more substantial and more service enriched. This may have a trade-off in fewer unduplicated clients served. They want to retain the current housing voucher system until mid-year of 2001, and master lease a block of rooms (20 units) in one building for short term emergencies with quick access. But the bulk of funding is planned for the master leasing of three sites: a medical respite & residential care facility as well as transitional housing in two new buildings. The overall funding is an integrated and collaborative approach designed to produce a larger housing effort for more people. Just as in other categories, there is a need for stretching the CARE dollars by combining them with other healthcare and housing initiatives. He listed the number of beds targeted for people with HIV and AIDS in each of the three facilities as well as the leased block of rooms. The three facilities are master leased hotels or buildings, with the provider having complete control and delivering professional, quality management. The leased block will be higher quality than the current voucher system, which uses some of the less desirable SRO hotels. DPH is putting out a Request for Qualifications (RFQ) next week and then holding a bidder's conference in hopes of putting together collaborative efforts among service providers.

GH said he did not favor helping the few rather than the many. He calculated the units of service and found it lacking as compared to the present system. He asked if the Council's approval needed to be given for this project, and if not, he wanted to know why. He wanted greater accountability on the part of the Housing Committee for justifying this change in the way CARE funds are spent. *AR* explained to Gary that this project represents the implementation of Council-approved priorities. That is what the Housing Committee is accountable for. *GH* returned to the attack based on assumptions about fewer people served and fewer units of service. *AR* agreed that this was a hard decision, but she pointed to the conditions in SRO hotels, which led to a great number of complaints from the very people served by vouchers. She asked the Council how members have felt about contributing funds to hotels operating in deplorable, sub-standard conditions. *GH* asked again about the approval process on this change to the emergency housing system. *JM* intervened to restate the two issues, one about units of service and the other about the process. *BH* spoke about his experience as a housing activist and about the amount of substantive discussion that has taken place in the Housing Committee. Yes, these are difficult issues. He has evaluated the issues from the viewpoint of a person with AIDS and from a housing services perspective. If his situation ever found him in need of emergency housing, he would certainly want more support services rather than just 28 days off the streets. This would help deal with a crisis situation in a better way. He finds it really encouraging that CARE dollars can be added to other funding sources and thereby provide something more substantial. He sees it as a model of how to cope with less money in the future. We can't do it all on our own. He would support having a vote on this plan at some point. *JM* clarified that a formal vote was not anticipated tonight and therefore had not been properly noticed to the public. So, a formal vote tonight was out of the question. He said this discussion was about consensus building. *CG* spoke about the past votes that went into Prioritization of projects, this being one such project. She, too, wants more collaborative efforts. She believes that the majority of clients prefer living in buildings that are more integrated, rather than identified as AIDS-only. Her job is to provide housing services to young people with HIV and in that context she has worked extensively with the hotel owners. She believes anything that can be done should be done to improve the living conditions of these places. Besides, 28 days is not enough to establish residency or improve their situation, so by

design clients are forced out, probably back to the streets. She also doesn't see any loss in overall capacity while gaining a great deal as a result of this change. *FGB* spoke from his experience working at the Mission SRO Collaborative, having seen many hotel operators and owners get away with a lot of abuses. The voucher system has not created any type of stabilization for people in crisis, despite all the good intentions. The discussion should be about how to improve the quality of housing by attracting other sources of funding. He encouraged the PWA Caucus to fight for this and try to build a constituency that puts pressure on officials in Sacramento and at City Hall. He supports this change (phasing out the AIDS emergency vouchers) and wants to build a broader movement in order to deal with the overall housing crisis. People with AIDS should be mobilized and be part of such a movement. *CC* said she felt two different modalities were being discussed—survival vs. stabilization. The current voucher system is about survival with one month of SRO and then you're on your own for the other 11 months. This new model is based on a more stable environment to do more interventions and encourage greater stabilization. Her concern is the potential effect on any other services that are provided by the AIDS Foundation to the voucher clients. Will some people be lost to services? She called for an outreach plan. *Margot Antonetty* said that there are doubts about the need for a vote of approval for this plan, but DPH Housing Services is committed to gaining the maximum input and consensus about how to best accomplish what are the stated Priorities of the Council, plus related goals and objectives. The discussion is important and they don't want to pursue a plan that some people are against. She also said it has been bad for housing that there has not been enough connection between the two modalities that Cecilia referred to, survival and stability. They need to be connected, as was the case for some clients of the integrated service network, which was able to use the vouchers for both survival and stabilization. That is why the emergency housing and support services, such as money management, go hand in hand. There are people who don't want to go to supported transitional housing. A certain level of structure is part of that route. There are people who would prefer emergency vouchers. This plan under discussion does contain 26 places per night for emergency clients to stay.

Kelly Wallace said high quantity of clients and quality of housing both make sense. There's no right or wrong between these two things, each of which make sense. The hard part is evaluating the effectiveness of vouchers in the past, because what's effective for one client may not be effective for other people. For some people a week may be exactly what they're looking for, whereas our longer-term goals may be very different. Specifically, he also got clarification about the transitions that clients may make within the residential care & respite facility, and the availability of short-term stays for emergency voucher clients in the block of 20 rooms. Michelle Long Dixon talked about the problems raised by "re-voting." This issue was discussed in the prioritization process of a year ago. The plan was voted on at that time. Now, we are in the implementation phase. She said that the work in the Housing Committee and in DPH has been reviewed by the I&E Committee. This is the established process for improving and tinkering with things in their implementation phase. This requires discussion, not further votes. She sees these housing plans as being very creative and innovative. So, the purpose of this Council discussion is to report back. Especially under the threat of steady losses in the CARE funding over the next few years, there will probably be other creative solutions that get shaped by necessity. We may be uncomfortable with the hard decisions and perhaps the loss of control in collaborative projects, which are able to leverage funds from other sources. She foresees more of this in the future. *GH* still felt that a vote was called for in this case due to the shifting of funds between two very different forms of providing service or care. Marc Trotz did a quick comparison of the numbers of beds and the number of unduplicated clients in the old system vs. in the new system. He explained that DPH did not invent the new plan out of its own desires for a change and that they could work with other constituencies in developing the three buildings as housing units with master leases. They didn't really need to include the CARE funding in order for this to proceed. Hank Wilson said that shelter capacity has not been increased while the

need has increased, and he saw this change as a further decrease in the capacity to serve people who are in serious emergencies. He said that service providers and other officials could do other things to improve the quality of SROs through rigorous enforcement of the building codes. Hold the owners accountable. He called for more effective connection with money management services in order to stabilize more clients. He sees the emergency vouchers as another important element of stability for some clients. With all the elements of the housing crisis, he sees an absolute need to maintain overall capacity of emergency rooms. It's a given that we simply don't know when the crisis will reach a breaking point for individual clients, many of whom see themselves as the victims of our past housing policies in this city. Some clients have benefited from the program the way it is now because they at least had someplace to go for the night. It's easy to generalize, but he asked for any numbers that may shed light on how many clients were stabilized. Marc Trotz responded to the latter issue saying that one of the first things taken up by the Task Force was to analyze the numbers provided by the AIDS Foundation. This information was used to conclude that the emergency vouchers were not working. Hank Wilson expressed that the vouchers, however, are the point of contact with some clients and are the point when other services are offered. He doesn't want to lose contact with anyone as a result of taking away vouchers. He concluded by saying that a rich city should not allow people to go without at least some shelter.

AR said that people really want something to happen for the clients during the period of emergency housing, and for the vast majority of people using the vouchers, nothing was happening. No benefits counseling, no money management, no nothing. There has to be something meaningful done with the CARE emergency housing dollars. She said the RFQ is scheduled to be released by DPH. She would like to clear away any doubt about motions or votes to put up roadblocks. *FGB* asked for the discussion to be continued in order to seek total consensus, with a vote next meeting. *AR* asked not to re-do this discussion with the possibility of new people present. While she would like to get everyone's support, she spoke against any motion to put the plan to a vote at the next Council meeting. She would like to schedule a discussion without noticing a formal vote. Marc Trotz said he wanted to maintain the overall funding for the emergency housing plan, including CARE funds, unless the Council decided to officially withdraw support. After voting 7-0 in the Housing Committee, he suspected it would pass here as well. He returned to the issue of conditions in the SRO hotels currently used for voucher clients. *JM* expressed appreciation for everyone's time, energy and passion for this issue. Michelle Long Dixon expressed a grave concern for a process that would bring back to the Council items already approved in Priority-setting. She felt that a re-vote would violate agreed-upon procedures. The I&E Committee is the place to discuss or argue about the implementation details and thrash out a consensus. From the Grantee's perspective, she doesn't want to see staff coming back to the Council every time a program (having over 100 programs) is modified. *JM* asked that the idea of voting be tabled and that members work toward greater consensus through the committee process during the next month. *GH* asked if the RFQ would still be released. *MA* said the RFQ is part of a process that must go forward in order to meet the financial obligations that are involved with buildings and leases. Russ Zellers advised a vote that is advisory in nature. *JM* said there would be no vote tonight. However, he asked all those generally in agreement with the direction of this change in emergency housing to raise their hands. Then he asked for those having serious reservations about this plan to raise their hands. This was merely offered to DPH staff as an expression of the Council's current stage.

XVI. New Business

Some clarification or further discussion on the latter topic will be a part of the next meeting.

XVII. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

October 23, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P									
2. Hazel Betsey	*HB*	P									
3. Jeff Byers	*JB*										
4. Bart Casimir	*BC*	P									
5. Veronika Cauley	*VC*	P									
6. Raymond Combs	*RC*	P									
7. John Conley	*JC*	P									
8. Cecilia Chung	*CC*	P									
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*	P									
11. Catherine Geanuracos	*CG*	P									
12. Fernando Gomez-Benitez	*FGB*	P									
13. Gene Gowdey	*GG*	P									
14. Laura Carcagno Guzmán	*LCG*										
15. Gary Harrell	*GH*	P									
16. Brad Hume	*BH*	P									
17. Sam Kaplan	*SK*	P									
18. Jeffrey Klausner	*JK*										
19. Gene London	*GL*	P									
20. Carmen Madríz	*CM*	P									
21. Michael Meehan	*MM*	P									
22. Allen Meyer	*AM*	P									
23. Jim Mitulski	*JM*	P									
24. Gregory Neumark	*GN*										
25. Jorge Ortíz	*JO*										
26. Stephan Oxendine	*SO*										
27. Ken Pearce	*KP*	P									
28. Alissa Riker	*AR*	P									
29. Susan Shea	*SS*										
30. Mike Shriver	*MS*										
31. Janis Takamoto	*JT*	P									
32. Bob Teague	*BT*	P									
33. Kelly Wallace	*KW*	P									
34. Robert Whitford	*RW*										
35. Mary Jane Wood	*MJW*										

An Overview of Key Changes to the Ryan White CARE Act
Adopted in the Ryan White CARE Act Amendments of 2000

Legislation reauthorizing the Ryan White CARE Act (S. 2311) unanimously passed both houses of Congress on October 5, 2000 and was signed into law by President Clinton on October 20th. Enactment of S. 2311 guarantees uninterrupted federal support for medical services for low-income, uninsured and underinsured people living with HIV disease. The former CARE Act legislation expired on September 30, 2000.

This document provides a general overview of the key changes to the CARE Act that are included in S. 2311. The complete text and additional legislative information regarding the final version of the CARE Act can be found on "Thomas, Legislative Information on the Internet" at www.thomas.loc.gov. If you would like additional information regarding reauthorization of the CARE Act, please contact the San Francisco AIDS Foundation Public Policy Department at 415-487-3080.

Common Themes Throughout the CARE Act Amendments

- *Improving Quality of Care:* Adopts measures to ensure that medical services funded by the CARE Act are consistent with the most recent U.S. Public Health Service (PHS) HIV treatment guidelines and that grantees implement improvements in access to and quality of medical services.

- *Improving Collaboration between Medicaid and State Children's Health Improvement Programs (SCHIPs):* Requires states and eligible metropolitan areas (EMAs) to establish formal linkages with these programs.

- *Enhancing Access to Early Intervention Services:* Supports service funding, program linkages and co-location of HIV testing and counseling services and CARE-funded medical care in an effort to reduce the length of time between HIV diagnosis and entry into care.

- *Reaching Individuals Living with HIV Disease Who Are Not Receiving Care:* The Health Services and Resources Administration (HRSA) will work with the Center for Disease Control and Prevention (CDC) to develop a method to estimate the number of people living with HIV disease who are not in care. State planning consortia and Title I planning councils will be required to use this method to identify individuals living with HIV currently not receiving care and to prioritize funding for services to these targeted individuals.

- *Enhancing Existing Quality Management:* Requires that CARE Act grantees establish or enhance quality management systems for CARE Act funded programs. These systems must include quality of care standards (Public Health Service HIV treatment guidelines as a minimum). The new law allows Title I and Title II grantees to expend 5% (but no more than $3 million) of the annual grant on such efforts.

- *Linking Support Services to Medical Care:* Requires that support services funded under the CARE Act facilitate, enhance, support, or sustain the delivery, continuity, or benefits of health services for individuals or families with HIV. All CARE providers will be required to have formal medical health care referral relationships, regardless of the service they provide.

Key Changes to the CARE Act by Title

The following guide highlights the key changes adopted in the Ryan White CARE Act reauthorization amendments by CARE Act Title.

Title I: Funding to High-Incidence Eligible Metropolitan Areas (EMAs)

1. **Planning Councils**
   The new Act requires that planning councils include HIV prevention providers, housing and homeless service providers, and HIV positive former prisoners or their representatives. These seats are in addition to the current list of required memberships, which include social service, mental health and substance abuse providers, public health agencies, hospital and/or health care planning agencies and affected communities including historically underserved groups. One-third of planning council members must now be HIV infected or affected family members of Title I service consumers who are unaffiliated with any entity that receives Title I funding (i.e., these consumers cannot be officers, employees, or consultants of such entities). Planning Council meetings must comply with Federal Advisory Council Act (FACA) regulations that require all meetings of the planning council to be open to the public and be conducted only after proper public notice. The Planning Council must also establish a process that provides public access to non–personnel related materials distributed to planning council members, including reports, meeting minutes, meeting agenda and any other documents distributed to the full planning council. The Department of Health and Human Services (HHS) will also be required to provide Title I communities with materials to train all planning council members.

2. **Use of HIV Data in Formula Funding**
   Currently, amounts awarded for the Title I formula grants are calculated using a 10-year weighted AIDS case band count to estimate the number of people living with AIDS in a given area. The new law will require that the most recent year of HIV case data be incorporated into the 10-year weighted case count beginning in 2005 unless the Secretary of HHS determines that HIV case data are not yet available throughout the country. The new law also requires an Institute of Medicine study of HIV case surveillance to determine if it is adequate for use in formula funding.

3. **Allowable Reductions in Title I Formula Funding (Hold Harmless Provision)**
   Former law limited allowable reductions in Title I formula funding to Eligible Metropolitan Areas (EMAs) by 1% per year, for a total of 5% during the five-year period the legislation was authorized. The CARE Act Amendments of 2000 adopt a graduated reduction of Title I formula funding as follows: 2% in the first year the hold harmless is needed, 3% in the second year, 3% in the third year, 3% in the fourth year, and 4% in the fifth year, for a total maximum reduction of 15% over the five years. If HIV data are incorporated into the formula calculation for Title I funding in FY 2005, the reduction for the fifth year will be lowered to 2%, for a total reduction of 13%. Reductions are based on the affected EMA's Title I formula allocation from the preceding fiscal year. The graduated reduction begins anew if there is an intervening year in which an EMA does not need the hold harmless provision.

Title II: Funding to States for Medical and Support Services (including the AIDS Drug Assistance Program)

1. **Use of HIV/AIDS Data in Formula Funding**
The changes in the formula related to the use of HIV data to determine Title II awards are identical to the changes included in Title I (see #2 above).

2. **Allowable Reductions in Title II Funding**
The new law maintains the provision that ensures that no state will suffer more than a one percent cut per year in non-ADAP Title II base funding. This means that states will receive no less than 99% of their base year award in the first year. It will continue to allow only an additional 1% reduction per year in the following years (for a maximum total reduction of 5% over the five years of the reauthorized Act).

3. **Supplemental Grants for "Emerging Communities"**
The CARE Act Amendments of 2000 create a new supplemental grant to states to provide services to "emerging communities" that are not currently eligible for Title I funding. This provision will not take effect until Title II appropriations (exclusive of ADAP-specific funds) exceed FY 2000 funding levels by at least $20 million. After this threshold has been met, fifty percent of any Title II funds above the FY 2000 funding level will be set aside to fund the new supplemental grants. Once this funding measure has been triggered, HHS will be required to ensure that at least $10 million is made available for these "emerging communities" every year. To be eligible, communities must have a population base of 500,000 and have reported between 500 and 1,999 AIDS cases in the past five years. In FY 2005, if HIV data are used in addition to AIDS data to calculate the formula allocations in Title I and II, the same will be used to calculate eligibility for the Title II supplemental.

Eligible areas with between 500 and 999 reported AIDS cases over the most recent five year period shall receive a minimum grant of $5 million or 25% of new Title II funds. Eligible areas with between 1,000 and 1,999 reported cases shall receive a comparable allocation of $5 million or 25% of new Title II funds.

4. **Competitive Grants for ADAP Funds**
The Act creates a new provision that sets aside three percent of all Title II ADAP-specific funds for a competitive grant program to increase access to HIV drugs for individuals who live in selected states with (a) demonstrated need for improved drug access, and (b) a significant number of consumers living at or below 200% of the federal poverty level. The provision requires that no state can receive a reduction in ADAP funds as a result of this new set-aside (i.e., holds states harmless from reduction that could occur due to this program). Eligible states must match the award at a rate of one dollar for every four federal dollars that they receive. States must also agree not to impose limitations on eligibility requirements or scope of benefits that are more restrictive than such requirements that were in effect on January 1, 2000. The criteria for awarding of grants will be developed by the Secretary of HHS.

5. **Partner Notification Programs**
The law creates a new $30 million annual authorization that would enhance existing partner notification, counseling and referral service programs. To be eligible, states must implement partner notification programs and reporting of those who test HIV-positive to the state public health officer in a manner recommended and approved by the CDC. Grant preference will be

given to states with HIV reporting systems that are "sufficiently accurate and reliable" for Title I and Title II formula allocation.

6. **Pregnancy and Perinatal Transmission of HIV – Mandatory Testing of Newborns**
The new law authorizes $30 million to address the issue of perinatal HIV transmission. The former grant program was funded through a $10 million annual allocation from the budget of the CDC. New language establishes a $30 million authorization of which $10 million will continue to be transferred from the CDC and the other $20 million will be subject to annual appropriations. The $20 million authorization will be available each year to (a) states with a mandatory testing requirement for all newborns or for newborns for whom the mother's HIV status is unknown, or (b) states demonstrating the most significant reductions in the rate of new cases of perinatal HIV transmission. A special rule for FY 2001 will reserve a minimum amount ($4 million) from new Title II funds for this purpose.

An increasing proportion of this funding (i.e., the amount appropriated in a fiscal year above the original $10 million) will be provided to states with mandatory testing requirements. The specific proportions are 33 percent in FY 01, 50 percent in FY 02, 67 percent in FY 03, and 75 percent in FY 04 and FY 05. The remainder of these funds will be provided to states based on such criteria as reductions in perinatal transmission and the incidence of HIV and AIDS among women of childbearing age. Individual grants to states from this set–aside will not exceed $4 million.

The Institute of Medicine will be asked to assess the number of HIV-positive infants born and the possible barriers that prevent the mother's obstetrician from offering her an HIV test in each state, and make recommendations to each state on methods to reduce the incidence of perinatal HIV transmission. In response to these recommendations, each state must submit a report to HHS by 2004 that describes the actions it has taken toward meeting the recommendations.

Title III: Direct Grants to Organizations for Early Intervention and Primary Care Services

1. **Preferences in Awarding New Title III Funds**
The Secretary will give grant preference in two tiers to service providers who (1) provide early intervention services in rural areas and (2) provide early intervention services in areas that are underserved.

2. **Increasing the Allowable Administrative Costs for Title III**
The new law increases the amount of Title III grants that can be spent on administrative costs from 7.5% to 10% to more accurately reflect the actual administrative costs associated with service provision.

3. **Establishing New Title III Capacity Development Grants**
Capacity development grants of up to $150,000 will be created for rural and/or underserved areas to expand capacity, preparedness, access to and expertise in the delivery of HIV primary care in these areas. These grants are not to exceed three years in duration.

4. **Partner Notification & Counseling**
Modifies existing Title III HIV counseling guidelines with a provision that requires providers, during post-test counseling for HIV infected individuals, to state that "it is the duty of infected individual to disclose their status" to partners and "emphasize that it is the continuing duty of the individual to avoid any behaviors that would expose others to HIV."

Title IV: Programs for Women, Infants, Children and Youth

1. **Grants for Coordinated Services and Access to Research for Women, Infants, Children, and Youth**
   The requirement to enroll "significant numbers" of women and children in research projects is eliminated, but the new law requires that grantees provide enhanced information and education to their clients on opportunities to participate in HIV/AIDS–related clinical research. Requires the HHS Secretary, through the National Institutes of Health, to examine the distribution and availability of ongoing and appropriate HIV/AIDS–related research projects, particularly in communities that are underserved by such projects.

2. **Limitation on Administrative Expenses**
   A new provision is included that requires the Secretary of HHS to conduct a review of the administrative and indirect costs associated with Title IV grants in an effort to establish a standard. This review is to be completed no later than 12 months after the CARE Act is reauthorized. No later than 180 days following the 12-month period for the review, HHS will be required to report on the relationship between the administrative cost of service delivery and recommend a standard for administrative and indirect costs. After this determination is completed, grantees will be required to cap administrative expenses.

Part F: Miscellaneous Provisions

1. **AIDS Education and Training Centers – Prenatal and Gynecological Care**
   A new provision is included that requires the development and distribution of protocols for women with HIV disease, including prenatal and other gynecological care. Such treatment protocols must be developed and disseminated within 90 days of reauthorization of the CARE Act.

2. **Authorizing Appropriations for Expanded Dental Reimbursement Program**
   The Act expands the definition of eligible dental entities to include accredited schools of dental hygiene. It also expands grants to dental schools to include those dental schools and dental hygiene programs that partner with community-based dental programs in underserved areas.

Subtitle B: General Provisions

1. **Coordination of Federal HIV Programs**
   The law creates a new requirement that the HHS Secretary must submit a plan to Congress every two years describing barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services.

2. **Plans Regarding Release of Prisoners Living with HIV Disease**
   A new provision requires HHS to develop a plan for the medical case management and delivery of support services to individuals living with HIV disease who are to be imminently released from either federal or state penal systems. The plan must be submitted to Congress no later than two years after reauthorization.

3. **Selected Audits**
   A new provision allows the Secretary of HHS to reduce the Title I or Title II grant to any grantee if it fails, in two consecutive grant years, to produce audits required of all federal grantees.

Annually, the Secretary of HHS will be required to select a representative sample of grantee audits, summarize them and provide them in a report to be submitted to Congress.

4. **Administrative Simplification: Coordination of Title I and Title II Grant Years**
A new provision requires the Secretary of HHS, no later than 18 months after enactment of the bill, to develop a plan for coordinating the distribution of appropriated Title I and Title II funding for grant making purposes. No later than two years after the plan is submitted to Congress, the Secretary of HHS shall implement this plan regardless of any other provision of law.

5. **Administrative Simplification: Biennial Application Process and Simplification**
A new requirement states that no later than two years after enactment of the bill, the Secretary of HHS must determine whether the administration and efficiency of Title I and Title II CARE grants would be improved by a biennial rather than annual federal grant making process. The HHS Secretary is required to submit a plan for simplifying the process for applying for Title I and Title II funding within 18 months after CARE Act reauthorization and to implement the plan no later than two years after the plan has been submitted to Congress.

Title V: General Provisions

1. **Institute of Medicine Studies**
The Secretary of HHS – in conjunction with the Institute of Medicine – must complete the following studies:

Health Care Financing: Identify and provide for use by health planners epidemiological measures and their relationship to the financing and delivery of primary care and health-related support services for low-income, uninsured, and under-insured individuals living with HIV. The study will consider availability and utility of health outcomes measures, the effectiveness and efficiency of service delivery, existing and needed epidemiological data and other tools for resource planning and allocation decisions, and other relevant factors. The study will include an assessment of the financial impact of reforming the Social Security Act to provide Medicaid eligibility to those in earlier stages of HIV disease.

State Surveillance Systems: The study must include a determination of whether the HIV surveillance system of each of the states provides adequate and reliable information on the number of individuals in that state that are diagnosed with HIV and whether such information is sufficiently accurate to be used for formula funding purposes. Recommendations will be issued to those states where the reporting mechanism is deemed insufficient.

The study on state surveillance systems must be completed no later than three years from the date of enactment. The study on health care financing must be completed within two years of enactment.

2. **Development of Rapid HIV Test**
The NIH is directed to expand, intensify and coordinate research to develop an HIV test that can be rapidly administered and the results rapidly obtained. Within 90 days after the CARE Act is reauthorized, the Secretary of HHS must submit a report to Congress on the progress made towards (and the barriers to) the development and availability of such rapid HIV tests. As soon as commercial distribution of a rapid HIV test occurs, the Secretary of HHS will establish guidelines that include recommendations regarding the availability of rapid HIV tests for administration to pregnant women who are in labor (or in the late stages of pregnancy) and whose HIV status is not known to the physician.

Steering Committee Meeting - Report
25 Van Ness, San Francisco, CA 94102
November 13, 2000

In Attendance:
Laura C. Guzman - Council Co-Chair
Gary Harrell - PWA Caucus Co-Chair
Laura Thomas - DPH / HHS
Michelle Long Dixon – DPH / HHS
Dara Coan - Harder + Co.
Jim Mitulski - Council Co-Chair
Elizabeth Maynard - Admin. Asst.
Stephan Oxendine – Council Co-Chair
Steve Feeback – Admin. Coord.

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HIV Health Services Planning Council - The Agenda
Date and Time - Approved
Minutes from 10/23 meeting. Last general meeting - housing report will not get voted on.

Reports:

Health Services - Require 45 minutes for: Department update, Report on reauthorization, Update changes in legislation that should be included in the Bylaws.

Harder + Co. Standards of Care - require 20 minutes. Report on the draft proposal about standards of care that include a budget and timeline. Three steps in the proposal: 1. Gather data - looking at standards of care criteria from other cities. 2. Write a Proposal - based upon the data gathered in various service categories. 3. Conduct Community Process - providing for feedback. Proposed Timeline: February, 2001 - Finish draft. March, 2001 - Begin a working group. June, 2001- Final Draft presented to the Council. End December, 2001 - Completed: Primary Care, Housing, Substance Abuse. Beginning 2002 - Development of drafts for other service categories. March, 2002 - Present for community input. Funding: Fiscal year ends in February. Harder and Co. are willing to provide a budget through February. The timeline may also need to be re-evaluated.

Steering Committee Recommendation - Council move forward with Harder + Co. proposal, schedule for vote.

I & E Committee - Susan Shea requested 45 - 60 minutes for 2 votes: 1. I&E recommendations for the prioritized core services 2. Which of any other recommended core services should be held harmless.

Housing Committee Report - Housing Committee implemented priorities from last year, and made recommendations to reform the emergency housing plan. These changes represent a significant change and several Council members wanted to be better informed as Housing Committee discussions were taking place. It was determined that such discussions can be reviewed at the I & E Committee meetings, whose function it is to determine if Committees (including the Housing Committee) fully follow the directives given by the Council. We give them our consensus in the form of Priorities. To keep the Council most current about changes being considered, it was determined that Steering Committee directives about the content of reports are adequate, but that Council members must be more attentive to read the reports of Committee activities. It would be useful to have recommendations coming out of Committee work groups, put before the Council in writing. It was determined that a review of this process to the Council would be helpful.

Further discussion about agenda: Time allotments discussed. Meeting adjourned early due to emergency evacuation for a bomb scare.

Report, November 6, 2000

HIV Health Services Planning Council
Implementation and Evaluation Comm.

I. Call to Order

II. Introduction of new participants

III. Review and approval of agenda

IV. Core Services Introduction

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- Background and Historical Perspective

Committee Co-chairs Susan Shea and Gene Gowdey - The council has made Core Services an issue in the past. The memorandums in the packet you have received, indicate the categories and sub-categories that have defined core services in the past. We may want to make amendments to these categories as we move to the next meeting where we will continue discussion of how we want to treat possible funding cuts.

The memorandums include: An overview and background issues, a document from HHS that highlights the issues that helped define Core Services and offers an historical perspective of what past Councils decided as far back as 1994, 1996 and 1998. We will be referencing the most recent Council decision, of 1998 in our discussion about Core Services.

Laura Thomas - A short summary of basic categories outlined by different planning councils fall into: survival services, medical care, housing, quality of life services, and access services (that help people access the other ones). Also included is a description of priorities from other years that are similar and come down to matching services with funding available. The most recent determination of Core Services by the Council is listed at the bottom of the November 6 memo. *(See Attachments)*

The most recent categories of Core Services that the Council approved are as follows:
1. Health Care - Primary Care
2. Health Care - Home Health
3. Health Care - Dental
4. Housing
5. Other support: Food, Substance Abuse, Mental Health, Case Management.

- Definitions to use for Core Services

When talking about Core Services, we are not talking about agencies that will be held harmless or not. The two discussions will be discussed separately. Even agencies considered to provide Core Services may be considered for a funding cut if that becomes necessary. It is important that the Council continue a definition of Core Services, so that if other distinctions are made, the definitions of Core Service and Other Than Core Services are clear.

It is possible that a scenario may arise where all Core Services will be held at a certain level of funding reduction and Other Than Core Services at a different level. It may be that the Council decides that all services should be kept whether they are Core or Other Than Core Services, with

both categories held in the same regard. We will also need to consider how the counties are going to factor into these scenarios.

The memorandum showing funding this year of CARE dollars for Core Services. In this budget, these are basic categories with the exception of Integrated Services which are combined with Primary Care and Case Management which is part of the same category of service. The second sheet shows service categories on the left hand side and sub-categories on the right hand side. The last shows major service categories that have been prioritized by the Planning Council in the past.

We still do not know what our award for 2001 will be. What we do know is that half of the award will have a 3% cut. The balance of the award will come in as the Supplemental. We do not know whether there will be a 3% cut in supplemental funding.

The purpose for this meeting and the meeting on the 20th is to guide the AIDS Office in the allocation of funding for the year 2001. We are to make recommendations about how to determine priority of programs. Changes to funding categories and contracts will be done at the AIDS Office. We are not allowed to suggest programs to be retained or cut. We are allowed to determine certain services categories and rank them in order of priority.

This is part of an ongoing process. We are looking at "standards of care" in addition to our five-year strategic plan, so that our discussions consider the bigger picture. We will continue to adjust and review the decisions we make. We will need to do special evaluations for some categories, such as Case Management, to determine how things are going and how we share dollars and streamline activities. We felt it was very important to get consumers and providers together who represent the community and find out what services are held dearest.

It is also important to note that even with recommendations that certain categories or sub-categories be indicated for reduction, there will be separate determinations made at future "Unfunds" meetings, which have been used in the past to back fill for funding cuts. It is possible that even with funding cuts there can be Rollover requests or Unfunds requests. Therefore, it is possible that a program or service could be targeted for fund reduction and still come out with level funding, once Rollover or Unfund requests are determined.

Public Comment Request - In respect of time, please limit comments to those that have not been referenced by another person. It is not the greatest numbers of people to speak that will determine the strength of your plea. We would like a balanced discussion, hearing from people in as many categories as possible. We would like an opportunity to hear from everyone.

Questions from Individuals -

1. *Are the items separated out in the Pie Chart (Attachments), being treated as separate categories?*

No, they may also be sub-categories. For example, Health Care is a category and Primary Care is one of a number of sub-categories (Home Health, Complimentary, Dental etc…)

2. *What are we actually talking about in terms of dollars and what numbers are we looking at with a 3% cut?*

We are looking at about a million and fifty thousand dollars, not including the Supplemental portion. We are assuming a 3% cut across the board.

- What services should be included in Core Services?

V. Public Comment:
Mental Health /AIDS:
Individual representing Instituto Familiar de la Raza in the Mission - We work with mental health in addition to a continuum of care services. I am here today as a representative of mental health AIDS workers. About 3 years ago there was a drastic cut in mental health funding which led to a re-organizing effort, to minimize the devastating effects upon the populations that we serve.

We have been successful in this re-organization and have managed to garner income from other sources, including MediCAL. We are available to advise people from other agencies about mental health issues and how they affect people living with HIV and what questions to ask in determining mental health needs. Our program is extremely integrated. We have worked very hard to integrate mental health services with other agencies, providing a continuum of care...a full 25% into ISPs. It is important to keep the system integrated with as much integrity as possible.

Individual representing Center for Special Problems - In the last three years, there has been a steady increase in triple diagnosed clients. These are clients living with AIDS who have mental health and substance dependence issues. Our records indicate that a full 85% of Ryan White clients are triple diagnosed. This is the reason that mental health should be considered as a Core Service for people living with HIV.

Issues that these clients face are complex. With a mental illness such as paranoid schizophrenia, they are unable to access housing and medical care, often rendering them homeless. Issues of housing and medical care cannot be addressed in such an individual unless the psychosis is addressed.

The needs of clients are most important to listen to. Surveys we have conducted with clients indicate that one-on-one services are most helpful. What is most difficult they indicated are that such services not more available to people who need them.

Mental health services are essential for triple diagnosed clients to adhere to medication and health care regimes. An example of the importance of mental health support in adherence is the case of Depression. Clients who are depressed without support tend to isolate and reduce functioning in life. They have less capacity and motivation to care for themselves and taking their medication is severely affected. It is essential that individuals such as this receive medication and support. Otherwise, their ability to survive is in jeopardy.

Numerous individuals - Complimentary Therapies: Complimentary Medicine is primary health care though in the past, the Council has not recognized it as such. Chinese Medicine is licensed in the State of California and has shown to be effective as a Primary Medical Care.

Traditional Chinese Medicine (TCM) is primary medical care for 20% of clients with HIV or AIDS. These are clients who cannot or will not pursue a western medical approach. In addition, many clients combine complimentary with western medical care and find that complimentary care is central to managing the side effects of medications which improves their ability to adhere to medical regimes. In TCM /Acupuncture we see many clients who are co-infected with Hepatitis C and who cannot tolerate recommended medications. TCM offers effective alternatives which effects their rates of survival. Clients also commonly experience Anemia, which effects the activity of HIV in the system. TCM treats Anemia effectively. Complimentary Medicine provides increased monitoring of a client's health as well as supports a client's mental and emotional health. Clients most often see their practitioners weekly or bi-weekly, enabling clients to form close relationships with their practitioners and share nuances of their health and well-being that a physician who is seen quarterly or monthly might miss. In TCM, we bridge a lot with other modalities including those providing mental health support.

The category of Complimentary Medicine has taken a big funding hit because of difficulty at certain agencies and agencies are struggling to service client demand. All agencies providing TCM and Acupuncture see a tremendous demand for services. In this city of San Francisco, 63,000 units of service have taken place. This is 585 unduplicated clients with agencies experiencing very long waiting list. There are clear accessibility problems.

In addition, under MediCAL, the category of Acupuncture is lumped together with psychiatry, podiatry, chiropractic, and mental health. This means that if a client receives counseling, as a result, she then cannot receive Acupuncture. Accessibility to an individual's Primary/Core Care in which Acupuncture certainly falls is diminished. Because Acupuncture is Primary Care for many with HIV living in the city and because it is considered Primary Care by the State of California, it should be an untouchable core service, continued to be funded in the city. It is essential that all folks eligible for MediCAL be on MediCAL. However, keep in mind that MediCAL only pays $16.00 per visit, which doesn't cover the basic cost. Other agencies experience similar financial restriction with MediCAL.

Questions?Comments:
Are people choosing complimentary only or do they combine with western medical care?
This varies depending upon an individual. Eastern and Western medicine together make a strong core of care for people to choose from.

Complimentary Medicine (cont.) - I know that people get suspicious of antidotal evidence. With Chinese Medicine we do have research data, but most of the demonstrated benefit to clients is gleaned from anecdotal evidence. This is because the cost of research is prohibitive and those who fund research (being pharmaceutical companies), do not direct funds to this category.

Client: I was in a wheelchair, unable to use my leg when I went to the Chinese Medicine College. I refused to give up and though I had my doubts, I began receiving Acupuncture. After 3 and ½ weeks I have full range of motion. Acupuncture is working for me and there are many other people who could benefit from this service. I would like for it to continue so that others too can have a chance.

Client: I am using both Eastern and Western medicine and the Eastern medicine is helping to counteract the side effects of the western medications. Some of these difficulties are HIV related and some are not.

Client: In 1993, when fewer medications were available, I was a Ryan White client and used Chinese Medicine. Now I am back on Western medications but through various changes, Chinese Medicine has been my most consistent form of health care. The benefits I received included not only physical, but emotional and mental as well. I now have health insurance, my health insurance company considers Chinese Medicine to be primary care and fully reimbursable. I would hope for Ryan White clients in the future, that Acupuncture would be available. TCM and Acupuncture can be a lifesaver for people. Remember, monitoring everyone does, medication not everyone will do.

Client: I have used TCM and Acupuncture to improve my mental and physical health. Five years ago, with the diagnosis of HIV, I was unable to work, without a home, and unable to function because of severe Depression. I also have Diabetes (Juvenile Onset) and experienced blood sugar swings such that I was being resuscitated by paramedics on an average of two times per month. I had access to the best medical care in the nation, yet was not able to utilize the support available to me. This changed remarkably when I received TCM via Ryan White Funds at the Quan Yin Healing Art Center with the inclusion of TCM into my regime. The Depression is gone, my blood sugars have stabilized, I have been able to return to work and stabilize my housing. I would not be here today without free access to Complimentary Medicine. Remember too that HIV can be treated as a chronic illness, which responds best in the long-term to complimentary or integrated care. With HIV, one need not develop AIDS; one need not end up in a Hospice.

Home Care: Many clients we work with would be unable to keep their stable housing without the support of an attendant. Fewer clients needing care in their home, are currently being served due to financial cuts. In our program we once had 15 attendants working and now we are down to 5. We also have a wait list of individual seeking Home Care. Many of the clients we serve are also triple diagnosed. Without this service they would not have the skills to keep a roof over their head, nor remember to take their medications. While Home Care is considered a quality of life service, I think it should be considered a primary care category. It helps clients manage their basic needs and connects clients that are unable to seek services with agencies in different locations, which provide basic care.

Housing: The housing crisis in San Francisco is severely affecting those with HIV and AIDS. What happens to people who are on long-term disability and lose their housing? They live with friends, move out of the area, or end up on the streets. A friend moved back to Alabama, leaving his entire support network, his entire existence obliterated because he had no housing. People are being forced out of their homes. Housing is essential for clients to receive and utilize medical care.

Integrated Services: It feels awkward to advocate for limited funding among individuals who I have worked and struggled with. I really want to support the Council regarding access to care and integrated services. Using the term, "integrated services," I do not mean what has been known as an ISP. It is absolutely true that we need to insure people can access more than one

service and utilize an integrated approach to their care, especially with clients experiencing multiple diagnosis. At Continuum, we work with many outside providers in partnership, to make their services available an integrated program. Having many services under one roof, better serves the client community who then avoid traveling across town to get what they need. It is exciting to see integrated services increased from 0 to 10%.

Alternative sources of funding are important to access, but keep in mind that MediCAL pays ½ to 2/3 of the actual cost. The main point I am trying to make is that main that we must always commit to being innovative, and not get stuck in a categorical or forced way of thinking...so unlike the thinking in San Francisco midst the AIDS epidemic. Granted, innovative thinking can be difficult in conversations like this where we fear we may lose something.

I think that as providers, we need to get together and ask, "Are we using these dollars to the best of our ability?" Are the triple diagnosed clients who cannot as easily access MediCAL (CARE) the ones who most need Ryan White dollars? Are there ways we can work more cooperatively? Are there ways to trade dollars?

Susan Shea - This is the role of the providers network. By law, the Council is not allowed to address these issues in terms of contracts.

Unknown Individual - Clients with multiple challenges require integration...all services coordinated. It might be wise to integrate CARE programs with the larger system of client care. It is difficult competing with other organizations doing great work for funds. It is clear all services are important. A team approach...further integrated services could increase client access and case management.

Benefits Counseling and Job Assistance: Insurance / Entitlements enable clients to access services available to them. It enables entry into primary care and into MediCAL. Job Assistance supports clients' re-entry into the workforce in ways that can support their health and survival.

Hospice Care: I urge us all not to forget those for whom new medications did not work. There are individuals dying with AIDS that cannot be here to speak for themselves. Hospice funding is necessary to provide support for these populations at a different stage in this disease. Priorities are different at different stages of this disease stages.

Peer Advocacy: Peer Advocacy meets clients where they are...Takes services to the streets. Peer Advocacy provides all manner of support including advocating for clients who may not be able to advocate for themselves.

Immigration Assistance: Immigration Assistance enables HIV infected clients, newly arrived in the U.S. to access support and care. This service is absolutely critical to some populations.

Western Medicine: Medical care provided through Ward 86 is Primary Care. Too often, access to Western Medical care is taken for granted. It is the fundamental care that clients must have access to. Remember that it, too, requires support in order to continue to be available for people.

Case Management: Case management is essential for hidden populations (for example, Native American populations). These populations often have different views of healing and of understanding the spiritual base of all life. Healing, for many in these groups originates from within. It is essential that the voices of these populations not be ignored. Culturally specific case management is essential for them to access to other core services.

Performance of Funded Programs: How is program effectiveness to clients determined? Perhaps there should be program monitoring to determine funding cuts.

Questions: Are cuts inevitable? Are Alternative Sources of Support and Funding Available?
MediCAL waiver for state?
ADAP waiver?
Increase volunteer support?
Political strategies?

Community Solutions:
All organizations serving HIV and AIDS clients are doing essential work. Are there ways as a community we can be innovative and work together midst these funding cuts? We are all on the same team!

Adjournment

City and County of San Francisco Department of Public Health

MEMO

DATE: November 3, 2000
TO: Implementation and Evaluation Committee
FROM: Laura Thomas, Health Planner LT
RE: Core Services

Here is a short summary of the model used by previous Councils to prioritize services. Over the years, various decision-making models have been used, both to prioritize new services and to cut existing services. I have attached descriptions of the process used from several Title I grant applications. All of the decision-making models shared the goal of matching resources available with priority needs of consumers, although different Councils in different years came to varying conclusions.

Core Services

In prior years the Council has used a hierarchy of needs model to prioritize services. This model is reflected in the current priority order of service categories. Maslow's hierarchy of needs is a model often used in the social and medical sciences to categorize basic life necessities. There are extensive discussions of its applications in the literature, and I can provide that to the Council if it would be useful. You may want to create your own hierarchy, however, based on your knowledge of the needs of people living with HIV/AIDS. All of the services are necessary for a comprehensive system of care and each one depends on the others. However, this does serve as a way to categorize each of the CARE-funded services. Any one service could fall into any of these categories for individual clients. Substance abuse treatment may do more to keep someone alive than food delivery, for example, and people may view services differently. Overall, however, it is possible to group services into these three categories and this can provide a useful framework for decision-making.

1. **Survival services**: The programs and services consumers need to stay alive. This has been defined to include health care, food, and housing. Food and shelter are generally recognized as basic survival needs for all people, although there are obviously many people who survive without housing. Primary medical care, including medications, for people with HIV/AIDS, is also a survival need, as it helps keep people alive and healthy.
2. **Quality of life**: These are services that improve the quality of life for people with HIV/AIDS, including mental health services and substance abuse treatment. This category also includes home health care, complementary care, and other services included in the "health care" category. Quality of life can be defined in a number of different ways, but the Council has in the past used this to mean those programs that enhance one's ability to function and improve one's experience of life.

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3. **Access to care services**: Services that help PLWH access the services in the above two categories. In other words, services that in and of themselves do not necessarily keep people alive or healthy, but enable them to get the services that do. This has traditionally included case management, transportation, benefits counseling, legal services, and child-care, among others. These services would be meaningless without a system of care to help people access; there is no point to transportation to medical appointments if there are no medical appointments available. At the same time, survival services rely on access to services to get consumers to them, and can often make a huge difference to multiply-diagnosed or severe need clients who would not otherwise be able to access them.

The model above evolved somewhat over time: the original model had only two categories – survival and increasing access to the system. The quality of life category was created to better describe services such as mental health and substance abuse treatment. The definition of core or survival services has also changed. For 1994, the Council counted primary medical care, housing, and food as survival services. In 1996, the Council defined core services as outpatient medical care, housing, food, and dental care. The 1998 Council expanded on that to incorporate outpatient care (including home health and dental), housing, food, substance abuse, mental health, and case management. They defined those services as being essential to the basic health and survival of severe need populations.

Other considerations

In addition to the hierarchy of needs model described above, Planning Councils have used other information and criteria in priority setting. The resources available are obviously a significant factor, but not one within the control of the Council. Other criteria are:

- Client need
- Availability of other funding
- Serving a severe need population
- Cost-effectiveness
- Ensuring services are provided for the full spectrum of HIV disease
- Capacity building
- Quality of services provided
- Utilization of existing services, and
- Importance of a service to the continuum of care.

November 6, 2000

To: Implementation and Evaluation Committee members
Other participants present

From: Gene Gowdey and Susan Shea
Co-chairs I and E

Re: Meeting of November 6, 2000

Core Services

Over the years, the HIV Health Services Planning Council has made efforts to define Core services in an effort to assist with the Prioritization of services that receive CARE funding. To my knowledge, there has never been any suggestion that any service categories were not desirable, given the presence of adequate financial resources. Essentially, there has been broad support for all of the programs and service categories that have existed throughout the history of the CARE Act.

However, in recognition that adequate financial resources may not be guaranteed indefinitely, the Council has maintained a standing list of both of the following:

1) List of service categories in rank order, with the overall most critical service categories at the top of the list.
2) List of service subcategories that the Council defined as Core Services.

It is important to note that the distribution of financial resources and/or the prioritization of categories and subcategories are independent from either of the above lists. Prioritization is accomplished by a fusion of many variables (Needs assessments, consumer input, utilization data, contractor opinion, DPH administrative data, etc.).

Decisions to shift funding, hold harmless categories for funding cuts, increase or decrease funding, etc. may or may not be associated with the above referenced lists. The Council makes these decisions at the time of prioritization. The lists could help shape or define funding decisions, if the Council determines this appropriate.

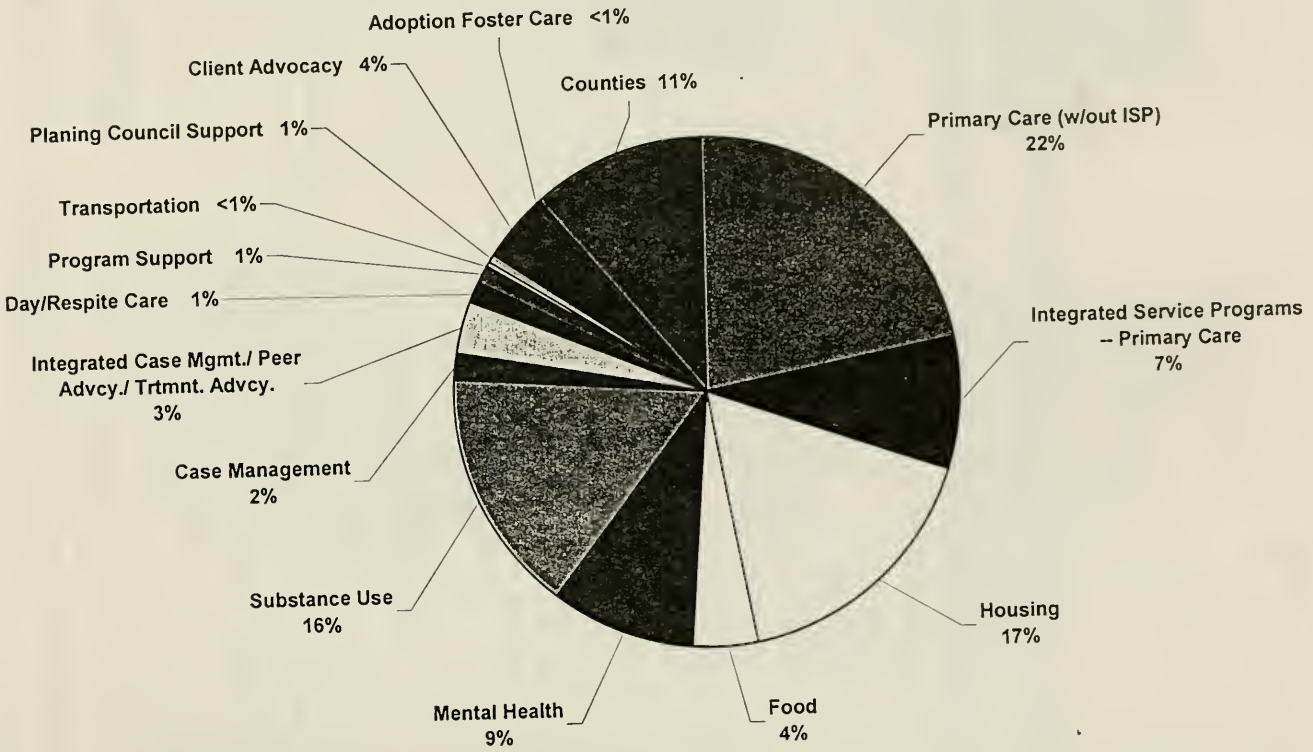
The definition of core services and the decisions to hold-harmless from funding cuts are separate. Defining core services will benefit the Council in the future if circumstances exist that force difficult funding decisions. It is important that the Council take a stance on these issues in order to sustain its historical approach to prioritization.

The most recent (and currently defined) core services that were adopted by the Council (from 1998) are as follows: (in no special order, major category listed first)

1. Health care / Outpatient primary care
2. Health care / Home health

3. Health care / Dental
4. Housing / Housing programs
5. Other Support / Food
6. Substance Use / Substance Use treatment
7. Mental Health / Mental health programs
8. Other Support / Case management

CARE-I FY 00-01 Funding by Service Category



Appendix C

FY 00-01 Service Categories

SERVICE CATEGORY	SUB-CATEGORY
HEALTH CARE	Primary Care
HEALTH CARE	Centralized Dental Care
HEALTH CARE	De-Centralized Dental Care
HEALTH CARE	Pharmaceuticals
HEALTH CARE	Complementary Therapies
HEALTH CARE	Home-based Home Care
HEALTH CARE	Facility-based Home Care
HEALTH CARE	Integrated Service Programs
HOUSING	Emergency Housing
HOUSING	Residential Programs and Subsidies
HOUSING	Transitional Housing
MENTAL HEALTH	Outpatient Mental Health
MENTAL HEALTH	Psychiatric Consultation
MENTAL HEALTH	Crisis Mental Health
MENTAL HEALTH	Residential Mental Health Services
SUBSTANCE ABUSE	Residential Treatment
SUBSTANCE ABUSE	Methadone Maintenance
SUBSTANCE ABUSE	Outpatient Substance Services
SUBSTANCE ABUSE	Detox
CASE MANAGEMENT	Case Management
CASE MANAGEMENT	Integrated Case Management
FOOD	Food Bank/Delivered Meals
FOOD	Nutritional Counseling
FOOD	Congregate Meals
CLIENT ADVOCACY	Peer Advocacy
CLIENT ADVOCACY	Benefits Counseling
CLIENT ADVOCACY	Legal/Immigration Assist
CLIENT ADVOCACY	Money Management
ADOPTION/FOSTER CARE	Adoption/Foster Care
DAY/RESPITE CARE	Adult Day Health Care
DAY/RESPITE CARE	Child Care
PLANNING COUNCIL SUPPORT	Planning Council Support
PROGRAM SUPPORT	Technical Assistance
PROGRAM SUPPORT	Training and Education
TRANSPORTATION	Transportation
COUNTIES	Marin County
COUNTIES	San Mateo County

Priority order of service categories for FY 2001

EMA: San Francisco, CA			
(1)	(2)		
#	Priority/Sub-priority Service or Community		
1.	**Health care** Ambulatory/outpatient medical care, including integrated care Dental care Medications Complementary therapies Home health care Hospice care Treatment adherence		
2.	**Housing**		
3.	**Food**		
4.	**Mental Health**		
5.	**Substance Use**		
6.	**Case Management**		
7.	**Client Advocacy**		
8.	**Day/Respite Care**		
9.	**Direct Emergency Financial Assistance**		
10.	**Transportation**		
11.	**Planning Council Support**		
12.	**Program Support**		
	SUBTOTAL		
**	**Grant Administration**		
	TOTAL		

Participants- November 6, 2000 HIV Health Services Planning Council
Implementation and Evaluation Committee

Name	Organization
Gene Gowdey	Co-Chair
Susan Shea	Co-Chair
Tom Calvanese	TARC
Gene London	CARE Council
Amy Cunninghis	SF AIDS Foundation
Bill Musick	Maitri
Marcy Fraser	Continuum/TLC
Jax McKee-Shapter	TLC
Steve Kohlstrom, PhD	Continuum/TLC
Greg Edwards	CARE Council
Elyse Graham	Immune Enhancement Project
Dan Nannero	Immune Enhancement Project
Misha Cohen	Quan Yin Healing Arts Center
Hank Wilson	Survive AIDS
Charlene Pugh	UOP School of Dentistry
Estela R. Garcia	IFR / AIDS MH Workgroup
Eugene Pilan	Westside AIDS CM
Elizabeth Maynard	CARE Council - Admin. Support
Phillip Watson	Shanti
Joseph Cecere	DPH AIDS Office
Celinda Cantu	DPH AIDS Office
Daisy Leyva	DPH - Housing
Christopher Scott Gomova	Native American AIDS Project
Ron Stranger-Horse	Native American AIDS Project
Jeffrey Shelton	Black Coalition on AIDS
LaMirldred Mackabee-Anderson	Iris Center
Leigh Illion	Tenderloin AIDS Resource Center
Carol Carbone	TARC
Sean Brooks	San Francisco Food Bank
Robert Strong	Shanti
Felicia A. Elizondo	Shanti
Manuel Sanchez-Mejorada	Shanti
Lami Ferer	FSA
Lawrence Marser	Ward 96 Positive Health Program
Sherilyn Adams	Baker Places ONC
Naomi Prochovnick	Lyon-Martin Woman's Health Services/WIDS
Catherine Geanuracos	Council / LSYC
Tiffany Mock-Goeman	Continuum
Elizabeth Colmello	SFRA
George Simmons	CCASF
Ken Bukowski	Positive Resource Center
Norma Wilcox	Westside AIDS Program

Hulda Brown	Quan Yin / CCCSF
Laura Thomas	DPH / HHS
Steve Oxendine	CARE Council
Charlotte Bobek	UCSF Positive Health Program / Ward 86
Jim Mitulski	CARE Council
Allen Meyer	Council / SFCCC
John Conley	Council / San Mateo County Health Dept.
Jim Dilley	AIDS Health Project
Margot Antonetty	DPH - Housing / CARE Council
Brad Hume	CARE Council
Laura C. Guzman	Council Co-Chair
Michelle Long Dixon	SF DPH AIDS Office
Marshia Herring	SF DPH AIDS Office

November Report - PWA Caucus Meeting

Meeting Date:	November 1, 2000
Meeting Place:	25 Van Ness Ave., Room 330-B
Meeting Time:	5:30 to 7:00 PM
Members Present:	Cecilia Chung (Co-Chair), Ray Combs, Gary Harrell (Co-Chair), and Jim Mitulski.
Others Present:	Richard Bargetto, HIV Consumer Rights Advocacy Project; Steven Feeback, minutes; Kenny Landes, Survive AIDS; and John McLaughlin, I-am-CARES.
Next Meeting:	Wednesday, December 6, 2000, 25 Van Ness, Room 330-B, 5:30-7:00 PM

Welcome and Introductions

Members introduced themselves and formulated the meeting agenda.

Public Comment

John McLaughlin related the services now being offered at I-am-CARES (Center for Administering Rehabilitation and Employment Services). They just got a 5-year federal grant to help with more counseling for clients who are interested in training opportunities, vocational rehab, job placement, or career advancement. He's looking for collaborations. He said clients could go to both agencies that provide these services: Positive Resource Center and his agency.

Concern about Our Voice and an Evaluation of Our Voice

Jim Mitulski read some lines published in a summary of a recent meeting of the HIV Contractor's group, which commented upon our discussions of the long-range planning document. They quoted a sentence that to them is somewhat inflammatory or objectionable. Jim suggested the possibility of some dialogue with this group, which none of the members present knew very much about. This was the first time that Jim had received a report from their monthly meeting, probably because of his taking a co-chair position. *Cecilia Chung* expressed her disappointment that more PWAs do not participate in the Caucus's meetings. She would like some outreach and attempts to gain greater participation in the planning work of the Council. The discussions that take place in the PWA Caucus may be seen as not representative of very many people with AIDS. Most service agencies have staff members as their spokespersons, rather than their satisfied clients. It is likely that staff will be the ones doing the complaining about possible upcoming cuts in funding to their category of services. But, in these planning processes, we generally don't have much input from sufficient numbers of clients. If we heard from more consumers, including ones using a wider variety of the services, we would be able to put forward our viewpoints with more authority. We would like to hear from more clients who are satisfied as well as those with problems. Among those with complaints, we could also try being more proactive in inviting them to take part in meetings of the Council's PWA Caucus or other ways of attempting to influence the direction of things. *CC* asked if those present felt we have a voice. Kenny Landes expressed the view that the Council is weighted toward "AIDS Incorporated," with more service providers who have a financial interest and less people with AIDS who have a health interest. *JM* said we don't know if we have a voice or not. We do have a mechanism for advancing our voice, but do we use it? *Ray Combs* agreed that we haven't raised the level of our

voice. He appreciates the PWA Caucus because the members themselves compose the agenda, rather than somebody else getting together beforehand to establish the meeting agenda. Others feel that the topics of discussion in other meetings are at times overly technical. It's hard to be articulate when so much of the material is going over our heads. *CC* spoke in favor of PWAs on the Council and others taking up the task of orientation or mentoring for new members.

The Role of People with AIDS on the Council

Members talked about the relatively low numbers of PWAs on the Council who are participants in the Caucus or active in other Council work. Many of the Council's 50% membership representing PWAs do not speak up and articulate the needs in the community. *RC* said he felt that he does not have the statistics at his fingertips, not being an agency employee, and therefore finds it difficult to fully participate in some of the Council's discussions. He views some of us as being at a disadvantage as spokespeople. But he conceded that there are other Council members who seem to not take part in any way, yet they occupy positions that are meant to articulate the views of people with AIDS. *CC* said, however, that other PWAs should be invited to participate in the discussions of the Caucus and by extension the community forums. Then, when we report to the Council we should make our voice as strong and clear as possible. In that way the voice of many more people will be heard. None of us wants to be a token person with AIDS speaking up on the Council. Since there are potentially 20 of us as Council members, there should be no tokens. We should be able to make our concerns heard. There are currently five or six openings on the Council and we would like to be involved in recruitment efforts. *RC* asked what is the Council's policy about the participation in meetings from members of the public and from service providers or contractors. He finds it slightly unusual that some meetings allow service providers to become a part of the meeting itself. There is not a uniformity of format for participation from those present who are not Council members. Some meetings seem to be weighted toward hearing primarily from service providers and agency employees. Some of us don't know the Council's procedures and processes. There is considerable variation among the Council's committees. Who is driving the agenda? There is definitely a need for consumers to be represented among the parties that are driving the issues and the agenda of this work. There are times when no one is going to invite participation; we simply need to invite ourselves. Public comment is part of every meeting, but is handled differently by different committees. Members are able to speak up freely and all members can influence the meeting's agenda.

Community Forum in January

We do view the forums as very important. Those present encouraged the Caucus, with support from the full Council, to be involved in more active outreach to the community. We have to find out more about what's going on in the community. Even though a damper has been put on some meetings as a result of tactics used by ACTUP San Francisco, the Council should be continually receiving community input. *CC* said that if we had more participation in the PWA Caucus, we might not need to do so many community forums. Others felt we still should be doing community outreach and input events. The question is can the forums, based on the experience of the past year, be made into something meaningful. *GH* appealed for the Caucus to set a date for the Tenderloin Community Forum. He feels that the time will be right in January to present information about the changes in the emergency housing vouchers and master leasing. This would be a great opportunity to explain the rationale and get some feedback. Several members volunteered to help organize the event in collaboration with the Tenderloin AIDS Resource Center, TARC, and Tom Calvanese. We would like to do it on a Wednesday evening, and settled on January 17th, around 7:00 pm or whatever is the best starting time according to TARC and their constituency. TARC has an excellent space for community meetings. We would like to contact all the peer advocacy programs to let them know about this event. Steve will get a list of the agencies doing peer advocacy. He will do a draft of a letter of invitation to attend the January meeting of the PWA Caucus and as a tool for getting the word out to clients about

the community forum. The purpose of the Caucus meeting in January will be dialogue between Caucus members and persons working as peer advocates.

Report from the Consumer Rights Advocacy Project

Richard Bargetto detailed his new cases from the month of October *(see attachments)*. He highlighted cases concerning primary care, including treatments, for homeless clients. Both clients having difficulty receiving appropriate services are complaining about the same agency, Mission Neighborhood Health Center. After some mediation Richard thinks that everything the clients are requesting will be forthcoming, but he is concerned about how much work it took for these two clients to receive satisfaction. He has sent reports about the facts to both the chief of DPH HIV Health Services and the Program Manager on this contract. In one year since Richard started his work, he has had three complaints about this provider. *CC* favored using such examples when the Council develops "standards of care." Do we have standards now about medication delivery as it relates to housing? The SF AIDS Foundation has a program providing daily amounts of medicines to homeless clients. Action Point may also be able to provide medications management. Homeless people have the right to make their own medical decisions, same as everyone else. The clinic's role is to provide quality primary care in a way that is integrated with the individual condition of the client. We want to see more integration of services and creative collaborations among service providers. It's not too much to expect that funded agencies complement each other's services rather than compete with each other. Apparently a sub-plot in this set of cases was that a lot of subjective criteria were being used to determine which clients could receive emergency housing vouchers in a SRO hotel, since the allotment of vouchers is a limited amount at that particular agency. There is no written policy. There was brief discussion about Monitoring Reports and Client Satisfaction Surveys. Richard also announced a new employee working with him and with Council Support. Her name is Elizabeth.

Housing Committee Report

GH attended the meeting (just prior) because of his continuing objections to how the Committee has formulated the changes to the emergency housing voucher system. He was not satisfied with the presentation during the past Council meeting. He reported that he has been partially convinced by what he heard in the committee meeting in that he is no longer opposed to the proposed change. There will still be access to emergency rooms for the night and those may still be arranged on short notice. The RFQ has been sent out. The bidder's conference and information meeting is next. Pros and cons of the new plan were briefly discussed. Whenever housing issues comes up, some members have anecdotes or personal experiences about how basic information concerning housing options is withheld from clients by some agencies, particularly the SF AIDS Foundation. Other services are out there as well, though they're not CARE-funded programs administered by the Foundation. The PWA Caucus would like to begin compiling a comprehensive view of services, presented from the point of view of the client. It would be a valuable contribution to the many people out there who are client advocates. We are less concerned about the sources of funding than we are about the total service system.

HIV CONSUMER RIGHTS ADVOCACY PROJECT
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PWA CAUCUS – OCTOBER 2000 REPORT

LAST MONTH'S CASES

	Type of Service	Agency	Issue	Outcome
1-	Housing	SFAF/Subsidy Program	Cultural Competency	Pending
2-	Dental	Community Dental – Castro	Quality of Care	Pending
3-	Legal	ALRP	Quality of Care	Resolved
4-	Housing	SFAF/HWL	Quality of Care	Resolved

1- Client has filed a grievance with the SFAF claiming that his subsidy was terminated without his full understanding and knowledge. The client, who is hearing impaired, attended a meeting @ SFAF whereby he voluntarily left the subsidy program in order to move in with his partner. At this meeting, client believed his subsidy would be returned to him if he moved out of his partner's apartment; however, because no translator was present at the meeting, miscommunication occurred. Client has filed a grievance claiming he did not understand his rights when he terminated the subsidy. The SFAF has provided a response. Client is not satisfied with the SFAF's response and will appeal the decision. Advocacy Project is assisting client with his appeal and monitoring the complaint.

2- Client claims that he was denied services for not paying the mandatory late fee of $10 for missed appointments and for a "bad attitude." Client claims that other patients arrive late for appointments but are not denied access to services. Advocacy Project is conducting an inquiry into the allegations.

3- Client claims that the AIDS Legal Referral Panel (ALRP) did provide an appropriate referral for his eviction proceeding. ALRP referred client to a volunteer attorney for legal services, but the client was eventually evicted. Client claims that his eviction was the result of poor advocacy from the attorney. Advocacy Project conducted an inquiry into the allegations and found that the referral attorney did not provide the best possible advocacy. This attorney has been relieved of any future referrals from the ALRP. Advocacy Project referred client to the California Bar Association for a possible malpractice action.

4- Client claims that he signed up for the Housing Wait List (HWL) over 5 years ago and has not received a subsidy. HWL claims that the client signed up for housing on 8/3/98. Advocacy Project conducted an inquiry into the date discrepancy by contacting numerous agencies who may some information. No physical evidence of an earlier application date was located.

NEW CASES

	Type of Service	Agency	Issue	Outcome
1-	Housing*	Peter Claver/Catholic Charities	Service Animal Acceptance	Resolved
2-	Dental	UOP	Quality of Care	Pending
3-	Med/Housing	Clinica Esperanza/MNHC	Quality of Care & Access	Resolved
4-	Med/Housing	Clinica Esperanza/MNHC	Quality of Care & Access	Resolved

1- Client was accepted into the Peter Claver Community (PCC) and he wanted to bring his service animal (dog) with him. Another resident claimed he had allergies to any dogs. Client agreed to forego living with his service animal in order to obtain housing. Advocacy Project began negotiations with PCC and the client to admit the service animal. Subsequently, the client was serv with unlawful detainer for violations of a stipulated judgment. Client was referred to ALRP for possible ADA violations. The service animal has been placed with the client's partner.

2- Client claims that he did not only receive unsatisfactory services from UOP dental clinic but also th even after one year his services have not yet been completed. Advocacy Project is investigating the client's claims and monitoring the grievance process. Additionally, the Advocacy Project is workin with the client to get his outstanding dental work completed by the clinic.

3- Client had three complaints. First, client claimed that he had 200 T-cells and requested on numerou occasions to begin medications (HAART). Client claims his requests were repeatedly denied. Second, client claims that although he only used 11 days of his housing voucher and requested additional days, these requests were also denied. Client claims he was still denied a housing vouche too. Third, client claims that he made numerous requests for a change of case manager, but his requests were not heard. After a case conference was called, the following resolution was agreed upon: Client was scheduled an appointment where he could request medications from his primary provider, the clinic would investigate whether they had access to any more vouchers to distribute to clients, and finally, client was allowed to change case managers. Advocacy Project also requested from the clinic the objective criteria they use to determine how clients get housing vouchers.

4- Client claims that although he did not use his entire housing voucher for this year, he was still denie Advocacy Project assisted client in locating a residential hotel if voucher became available. After a case conference was called, the clinic would investigate whether they had access to any more vouchers. Advocacy Project also requested from the clinic the objective criteria used to determine which clients get vouchers.

* Duplicated Client

Referral Calls:	Derek Silva Grievance Procedures	2
	Peter Claver Grievance Procedures	2
	ALRP Grievance Procedures	1
	UOP Grievance Procedures	1
	HIV C.R. Adv. Proj. Griev. Proc.	1
	Positive Resource Griev. Proc.	1
	ALRP Legal Services	2
	Total	10
Total Volunteer UOS:	4	

(Report prepared by Richard Bargetto on 10/31/00)

November Report
Housing Committee

To:	Members, HIV Health Services Planning Council
Meeting Date:	November 1, 2000
Meeting Place:	25 Van Ness Ave., Room 330-A
Members Present:	Margo Antonetty, John Conley, Catherine Geanuracos, Gary Harrell, Carmen Madriz, and Jim Mitulski
Others Present:	Sherilyn Adams, Baker Places; Chris Callandrillo, CCASF/HIV Direct Svcs.; Tom Calvanese, TARC; Carol Carbone, TARC; Elizabeth Colomello, SFRA; Amy Cunninghis, SFAF; Steven Feeback, minutes; Gail Gilman, Bridge Project; Chris Harris, SFRA; Daisy Leyva, DPH (Housing); George Simmons, CCASF/HIV Direct Svcs.; Pam Sims, SFRA; and Laura Thomas, DPH-HHS.
Next Meeting:	Wednesday, Dec. 6, 2000, 25 Van Ness, Room 330-A, 3:00-5:00 PM

Introductions

Catherine Geanuracos welcomed everyone and said that the regular co-chairs wouldn't be able to make it to the meeting. She passed around copies of the agenda and asked if anyone had additional items.

Follow-Up to CARE Council Meeting Discussion

One part of this topic is the issue of voting or re-voting about projects already part of last year's Prioritization process. *Margot Antonetty* told everyone that the RFQ had gone out, and its elements will not be changed by any future decision with regard to partial funding from the CARE Council or not. As of the moment, the AIDS emergency housing is part of the RFQ and the overall project for more transitional housing with supportive services. The three facilities were briefly reviewed along with the provision for a block of rooms to be leased in one hotel for emergency use. *Gary Harrell* asked DPH Housing Services to estimate the units of service provided now in the emergency voucher system and the units of service to be provided under the new system. Amy Cunninghis spoke about the current contract. After additional money was added in "Unfunds," about 700 clients were provided with an average of three weeks housing vouchers. This averages 41 people per night. It's hard to compare the old system with the new because units of service can be defined in an entirely different manner. *John Conley* said he viewed it as a comparison between apples and oranges—two very different ways of providing service. He said he feels that based on the prior discussions for Prioritization the Council does want to support the new plan with supportive services such as those in the RFQ and does want better quality housing for emergencies. He believes that the Council didn't say that it wanted to reduce the number of vouchers available to clients. He doesn't believe it is a direct trade-off that more service equals less emergency spots. Thus, it's a question of implementation and he doesn't think the Council wanted to reduce access to vouchers, as a way of paying for more services in transitional housing units. He wanted to know how much would be remaining in the voucher system. He agrees with those who say there are some people who we may not be able to reach unless we have something to give them, such as a hotel voucher. He thinks the new services would be great for people with HIV. But, what's going to be left for those clients who have a different idea of what's appropriate housing for them? *MA* responded that the block of 20 units in one hotel would be available to access on short notice, just as in the current voucher system. The rules about how long people can stay have not been formulated. *JC* still wanted to know how many vouchers would be available for people who want a night in a hotel, tonight, and don't want any other services. *CG* answered that it seems to be that after next June, there will be no money left for housing

vouchers. The 20-room block of rooms will function in a way similar to the current system of accessing a short-term hotel room. The quality can be improved by having the single block, rather than scattered site rooms. That will represent a cut in half for the number of rooms available each night. However, the AIDS Emergency Fund will also still operate its program that includes emergency vouchers. There are other programs outside the CARE funded system and these can be better integrated through improved case management. *JC* asked about the type of behavior that will be allowed in the hotel with 20 rooms set aside for emergencies. *MA* responded that there are no rules that attempt to monitor drug use behavior. She mentioned a program now functioning as part of Baker Places. It accepts special-needs clients especially those released from the General. There isn't a lot of control or structure. It's not required that clients go through an intake or that they access any services. Staff does offer help, but it is offered from the standpoint of harm reduction. She also reiterated that by leasing a block of rooms, they have a means of applying pressure to the hotel owner/operator, thereby getting repairs done or questioning the front desk entry procedures for example. The new hotel with 20 rooms has not yet been identified, and there have been no negotiations as yet. It will not start until after the three other facilities are up and running.

CG returned to the confusion surrounding a vote or a re-vote on this issue at the Council level. Laura Thomas reviewed the Council's purpose (prioritization by service categories and fund allocations to those categories) and its funding process (budget requested from HRSA vs. the grant received). Implementation is up to committees and to DPH. Re-votes are necessary in order to move money between service categories. This current situation isn't even a move between sub-categories. Then, the I&E Committee reviews and evaluates the implementation. The Prioritization of last year mandated some significant changes in the way housing services were to be provided, to address some needs that had been identified. Now, we're at the point where we as a Council can be involved in explaining these changes to clients and consumers. The Council has a continuing role because it can support this implementation plan or express concerns until it is done properly for clients. Thus, a simple yes or no vote would not be very useful either as a way of supporting it or as a way of expressing concerns. Perhaps there are unresolved issues, such as the points of access to the 20-room block of units. So, this discussion is very useful. The new SPNS grant for housing was discussed to determine that it also is complementary with the objectives of the Council.

The Housing Committee would like to work on outreach concerning the changes in emergency housing and to support the PWA Caucus in its community forum, as a component of the outreach particularly in the Tenderloin. *MA* reiterated that the vouchers were not going to become unavailable in January. It will be several more months before they are phased out, so there shouldn't be any panic about this change.

I&E Committee meetings on Core Services

CG explained that the next two meetings are set up to have participation from a great many service providers. She encouraged Council members with an interest in housing issues to attend one or both of these committee meetings, in order to advocate for housing services.

Update: Franciscan Towers Contract

MA gave further information on this matter, which had been brought before to the Housing Committee and to the full Council. For the housing provider, this contract was no longer a good match of clients and services. The history dates back several years. Franciscan Towers is a significantly different location than the former Ambassador Hotel. Some clients have not fit in at Franciscan Towers. The units available were at times not being occupied. And, the Case Management services were not being utilized. DPH Housing Services has searched for a new contractor, but has not been successful. The way this problem will be resolved is that current occupants will continue to have their subsidies paid by the contract. No new tenants will be placed there and no units will be held on reserve. Money management services are still available for the clients. The savings in this contract will be re-directed from this

housing project to the new emergency housing plan, depending on the "Unfunds" procedures. Tom Calvanese expressed a concern that he has heard from other people in the community, namely that the scenario that has occurred for some clients who didn't fit into the environment at Franciscan Towers is relevant to the three new facilities being planned for transitional and emergency housing (prior topic). Might the target population not fit into the new mixed-use facilities? *MA* pointed out an important difference between the two examples, namely that the new buildings would be under more supervision by DPH, while the Franciscan Towers was not. This impacts the operations, especially when the issue is drug use behavior and harm reduction policy. Franciscan Towers could decide whom to allow as tenants, while the new facilities will handle that decision in accordance with DPH guidelines. Lutheran Social Services tried very hard to make the situation at Franciscan Towers work for clients, but it couldn't be accomplished at this building. Laura Thomas wanted to reinforce the idea that this is an example of what can happen, and it drives home the point that all the service elements need to be well matched for housing plans to remain viable. Tom Calvanese said he thought there is an inherent tension between property management on one hand and supportive services/client advocacy on the other hand. This is preferable to a situation in which one contractor is providing both of these functions. He reiterated his concern more about the desired environment and said he hoped there would be a good match in these new facilities. The savings in this contract may alternatively be used for subsidies or for the transition from emergency housing vouchers to the 20-unit block of rooms for emergency use. These options will be discussed further in DPH Housing Services.

December Agenda

One item is the transition away from emergency vouchers and the educational outreach to the community. For example, elements now completely settled, such as the change from scattered site to a concentrated 20-unit block of rooms, can be shared with the public. A timeline for December through July would be helpful.

Membership Committee November Report

Meeting Date: November 2, 2000

Meeting Place: 25 Van Ness Ave., Room 330-A

Meeting Time: 5:30 to 7:00 PM

Members Present: Laura C. Guzman, Ken Pearce, and Janis Takamoto

Others Present: Steven Feeback, minutes; and Laura Thomas, SFDPH.

Next Meeting: Thursday, December 14, 2000, 25 Van Ness, Room 330A, 5:30-7:00 PM

Introductions

Review of Changes to Ryan White CARE Act

Laura Thomas shared some preliminary information about legislative mandates in the reauthorized Act just passed by Congress and signed by the President. She will prepare a more complete report and present it to the full Council. Some items will require that the Council examine its Bylaws and decide if and how to make changes. The Membership Comm. began outlining some of the concrete issues. Bylaws changes take some time to notice (30 days or more of advance notice) and vote on.

Chair of this committee

Janis Takamoto asked Ken Pearce if he would take over as Chair of the Membership Committee. He was approved by acclamation.

Analysis of Current Membership and Areas of Representation

Laura Thomas passed out a memo she prepared. According to her analysis, the Council is in compliance with its bylaws in most areas. The one significant discrepancy is the percentage of the Council's seats occupied by people who are openly HIV-positive. In this area there is under-representation because the bylaws say that at least 50% of the members should be HIV+. Currently, 16 of 34, or 47% of the members are in that group. She concluded that the top priority for recruitment should be HIV+ members in order to bring representation up to the 50% threshold. On another representation front, she said that the Council is very close to the overall racial/ethnic demographics of the epidemic in this EMA. However, Latinos and African Americans are under-represented, and she said Latinos in particular should be targeted for recruitment and appointment. Next, she mentioned gender representation, with current membership being 28% women, including transgender women. By tradition, the figure is usually closer to 40% or even more. Also substance abuse services and mental health services are required areas of representation that are not adequately covered at this point. There are some new requirements: HIV prevention providers, homeless service providers and HIV+ former prisoners or their advocates. All of these are currently included. The other key new requirement is that one-third of the Council members must be consumers with no conflict of interest. All three members (Ken, Laura, and Janis) will take an active role in recruitment efforts with these objectives in mind. Several potential candidates will be invited to attend the next meeting of the Membership Committee, including one who has attended Council meetings for the past few months.

Attendance and Compliance Issues

Only one Council member has been violating the minimum mandatory requirements. Laura Guzman volunteered to deal with that non-compliant member personally. She will get a resignation. The same member is also out of compliance with the Fair Political Practices Commission.

Orientation and Training

We will try to find a videotaped version of our basic Council orientation. Laura Thomas will mail copies of the HRSA manual, the Title I Application, the 5-year Plan, the Bylaws, and the most recent Epi Report to new members. The last orientation was about eight months ago and was judged to have had a very good format. A guidance document on Priority setting and decision making is being drafted by the I&E Committee. This would be the foundation of a suitable refresher-training for many members. Membership Committee wants to continue being active in planning for orientation of new members and periodic training for all members. Janis will contact other new members to coordinate schedules for an upcoming orientation session.

Issue of Stipends/Reimbursements for Council Members

KP asked for some further clarification of policy and procedure, in order to convey it accurately to prospective nominees. Reimbursement requests are readily honored by the Contractor in the cases of lost wages, transportation expenses and/or childcare. Among current Council members there are some who favor the use of stipends because they believe incentives are helpful in gaining full participation from consumers and they believe there are people who very much need the small amount of monthly stipend support. But, the directive from HRSA and DPH HIV Health Services have decided that stipends such as those paid for a short while by San Francisco and other EMAs were in violation of the legislation. They have to be paid as reimbursements for actual expenses. Ken Pearce and Laura Guzman asked that any members please speak to them personally if they are in need of providing backup for their expense category. The objective is to make it easier to come to meetings, especially the ones at City Hall. They will ask Michelle Long Dixon to consult with the HRSA program manager. The other issue is that currently Council policy is in violation of HRSA rules. DPH would be more comfortable if the policy got changed.

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Brad Hume	Hume	Brad	wynsok@worldnet.att.net
Carmen Madriz	Madriz	Carmen	cmadriz@php.ucsf.edu
Catherine Geanuracos	Geanuraco	Catherine	catherineg@lsyc.org
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Jim Illig	Illig	Jim	jillig@openhand.org
Jim Mitulski	Mitulski	Jim	Mitulski@aol.com
John Conley	Conley	John	hs*jconley@mail.co.sanmateo.ca.us
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DRAFT

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Nov. 27, 2000 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes**, 10/23 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *HIV Health Services of SF-DPH*	**4:55 PM**
	Changes in CARE Act with Reauthorization; Council's Bylaws	
	• *Standards of Care*	**5:35 PM**
	Presentation by Harder +Company — **VOTE**	
	• *Council Support Budget* — **VOTE**	**5:50 PM**
Break		**6:00 PM**
	• *Steering Committee*	**6:20 PM**
	Clarification concerning process from last meeting	
	• *Housing Committee*	**6:25 PM**
	Emergency/Transitional housing update	
	• *PWA Caucus*	**6:30 PM**
	• *Membership Committee*	**6:35 PM**
	• *Implementation & Evaluation Committee*	**6:40 PM**
	Core Services Discussion – **VOTE**	
	Hold Harmless Discussion – **VOTE**	
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type of meeting	Location	Time
Mon	12/4	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	12/6	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	12/6	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	12/11	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:30 PM
Thurs	12/14	Membership Committee	25 Van Ness, Room 330	5:30 – 7:00 PM
Mon	12/18	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	1/3	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	1/3	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	1/8	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM

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Attention

This mailing is being sent a few days early to accommodate the vacation schedule of staff. There will be additional materials following the Implementation and Evaluation Committee meeting of Nov. 20, which will be mailed separately next week and/or distributed at the Council meeting on November 27.

Steve

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Minutes, Nov. 27, 2000 **HIV HEALTH SERVICES PLANNING COUNCIL**
Draft until approved by Council at next meeting

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I. Call to Order
4:35 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
This agenda was accepted by consensus.

IV. Review and Approval of Minutes
10/23/00 Council Meeting Minutes – *FGB* called for a correction on page seven of the 10/23 Minutes. A motion was made to approve the Minutes, seconded, and passed unanimously but with three abstentions.

V. General Announcements
Mary Jane Wood announced changes taking place with the State of California planning body. She has been representing the San Francisco HIV Health Services Planning Council. She reported that Prevention would once again be a separate group from the Health Services. The recent statewide meeting also voted for a resource allocation formula applying to Title II funds for the upcoming year. She anticipates slight increases for San Francisco and San Mateo counties, with perhaps a decrease for Marin County, depending on whether or not prison populations (San Quentin) are included. *Michael Shriver* announced that he is resigning his seat on the Council because of his new job in the Mayor's office as AIDS Policy Advisor. He'll be attending Council meetings in that capacity. *Jim Mitulski* said that he is no longer serving as pastor at MCC.

VI. Public Comment
Bruce Riggs told the story of a friend of his who was recently discharged from the Dementia ward at St. Mary's Hospital after 13 months. He received no discharge planning or assistance. Bruce's home is not suitable for someone in poor health because of the stairs, but there seems to be no other housing option for him. He needs professional help. Michael Petrelis of AIDSstatistics.com made some complaints about Jimmy Loyce, new director of the AIDS Office, and the suggestion that services rather than salaries would be cut as a result of reduced federal funding. He also complained about the Council not having a web site that is fully functional for public access. Finally, he drew attention to funding issues concerning HIV prevention and to the numbers of people with HIV in San Francisco. Carla Wilson, Executive Director of Quan Yin Healing Arts Center, offered her viewpoint on Traditional Chinese Medicine and said that the sub-category of Complementary Therapies should be "held harmless" by the Council, given that funding cuts had already taken place in that area.

VII. Reports

VIII. HIV Health Services of DPH
Laura Thomas delivered a detailed report concerning changes in the Reauthorized Ryan White CARE Act, which will have an impact on the work of this Council. There will definitely be cuts in the formula portion of the grant to the San Francisco EMA each year of the five years authorized by the new CARE Act. The grant for next fiscal year (starting March 1) was submitted last fall, and we should be hearing from HRSA soon, thereby providing us with the exact dollar amount. She used a set of overhead transpareneies for her presentation and this information is re-printed here *(see attachments)*.

IX. Standards of Care

Dara Coan gave a brief overview of the Harder +Company proposal for the development of Standards of Care. This is a successor to the Client Satisfaction survey work that Harder +Company was doing for the Council. By establishing standards of care, the Council will be able to assess the quality of service delivery across the system. She emphasized that adjustments can readily be made, based on the Council's needs and concerns. A budget correction was noted. Case Management is a category that will be examined separately. *Jim Illig* felt that materials and research from other EMAs, particularly Oakland, could be utilized in San Francisco. The money saved on this consulting work could then be put into direct services. Susan Shea differed with this view and said that she thinks the important part of this work is engaging the participation of service providers in a process of discussing the appropriate standards of care. She wants a dialogue between consumers and providers. The manuals and standards from other EMAs can be referenced in this process but cannot simply be adopted. In this case, it's not the product that we're paying for, but rather the process to formulate a product and agree on standards of care for our EMA. *Ken Pearce* said that about half the budget was for the process and about half for development of the product. Perhaps, by using a draft from another EMA, money could be saved. *Cecilia Chung* talked about the differences in demographics and other issues that prevail in San Francisco. Consumers want to be heard in order to reflect the realities of living in San Francisco. *KP* and others continued to object to the scope of work and the budget implications. Dara Coan said the focus of the project could be changed to reflect greater emphasis on the community process and less emphasis on data collection and synthesis. It was moved and seconded to approve the proposal as it stands. *SS* supported the expenditure of this year's research money on this project related to standards of care. It was moved and seconded to approve the proposal as submitted. The vote was 15 in favor and 6 opposed (see Roll Call Sheet, Column 2).

X. Council Support Budget

Stephan Oxendine made a presentation about the need for training of Council members and outlined a budget for accomplishing this. *Robert Teague* said that the trainings and the curricula could be provided without cost by the AIDS Education Training Center.

XI. Steering Committee

Jim Mitulski clarified the process concerning votes from the preceding meeting. *SO* elaborated by reminding everyone of the necessity to read the Council materials in advance of the meetings and come fully prepared.

XII. Housing Committee

Margot Antonetty presented a brief report on Transitional housing and the emergency vouchers. She also added some information about the contract with Franciscan Towers, continuing to pay individual subsidies for the clients who are staying in their apartments. Other services will be transferred. The savings from this contract will be shifted to Transitional and Emergency housing.

XIII. PWA Caucus

Gary Harrell said the Caucus would like to engage in dialogue with the HIV Contractors Assn. and with people working as Peer Advocates. He was not happy that some other committees had not been attending the Steering Committee in order to assist with planning for the upcoming Community Forum. *CC* asked that more of the members who are HIV+ try to attend the Caucus' meetings.

XIV. Membership Committee

Ken Pearce said that the committee is keeping track of attendance records and will be sending letters to those who are not fulfilling their attendance responsibilities. Ken was elected chair of this committee. He outlined the process for nominating new members and thanked other members for expressing a willingness to be involved in finding new people to serve on the Council.

XV. Implementation & Evaluation Committee

Gene Gowdey passed out the committee's recommendations for Core Services. He explained the definition that had been utilized in the committee's discussions about Core Services: essential for basic health and for the survival of severe need populations. He also detailed the changes from the last time the Council voted on the topic of Core Services. Next the committee will be working on which services, if any, to "hold harmless." All of this is in preparation for dealing with reductions in funding. It was moved and seconded to accept the I&E Committee's recommendations. This was passed unanimously 21-0 (see Roll Call sheet, Column 3).

XVI. New Business

XVII. Adjournment

HIV Health Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

November 27, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*	P	Y	Y							
2. Hazel Betsey	*HB*	P	Y	Y							
3. Jeff Byers	*JB*	P	Y	Y							
4. Bart Casimir	*BC*										
5. Veronika Cauley	*VC*										
6. Raymond Combs	*RC*	P	Y	Y							
7. John Conley	*JC*										
8. Cecilia Chung	*CC*	P	Y	Y							
9. Mark Dunlop	*MD*										
10. Gregory Edwards	*GE*										
11. Catherine Geanuracos	*CG*										
12. Fernando Gomez-Benitez	*FGB*	P	Y	Y							
13. Gene Gowdey	*GG*	P	N	Y							
14. Laura Carcagno Guzmán	*LCG*										
15. Gary Harrell	*GH*	P	Y	Y							
16. Brad Hume	*BH*										
17. Sam Kaplan	*SK*	P	N	Y							
18. Jeffrey Klausner	*JK*										
19. Gene London	*GL*	P	Y	Y							
20. Carmen Madríz	*CM*	P	Y	Y							
21. Michael Meehan	*MM*	P	Y	Y							
22. Allen Meyer	*AM*	P	N	Y							
23. Jim Mitulski	*JM*	P	Y	Y							
24. Gregory Neumark	*GN*	P	N	Y							
25. Jorge Ortíz	*JO*										
26. Stephan Oxendine	*SO*	P	Y	Y							
27. Ken Pearce	*KP*	P	N	Y							
28. Alissa Riker	*AR*										
29. Susan Shea	*SS*	P	Y	Y							
30. Mike Shriver	*MS*	P									
31. Janis Takamoto	*JT*	P	Y	Y							
32. Bob Teague	*BT*	P	N	Y							
33. Kelly Wallace	*KW*										
34. Robert Whitford	*RW*										
35. Mary Jane Wood	*MJW*	P	Y	Y							

Support Budget 1+E

DRAFT

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

Dec. 18, 2000 4:30 PM

AGENDA

I.	**Call to order**	**4:30 PM**
II.	**Roll Call**	**4:32 PM**
III.	**Review and Approval of Agenda**	**4:34 PM**
IV.	**Review and Approval of Minutes,** 11/27 — **VOTE**	**4:36 PM**
V.	**General Announcements**	**4:40 PM**
VI.	**Public Comment**	**4:45 PM**
VII.	**Reports**	
	• *SF Department of Public Health*	**4:55 PM**
	Presentation on Shigella by Dr. Gwen Hammer	
	• *ADAP Utilization Study*	**5:15 PM**
	Presentation by Mike Shriver and Steve Morin	
	• *Membership Committee*	
	Nominees – **VOTE**	**5:50 PM**
Break		**6:00 PM**
	• *PWA Caucus*	**6:20 PM**
	• *Implementation & Evaluation Committee*	
	Hold Harmless Discussion – **VOTE**	**6:40 PM**
	• *Housing Committee*	**7:20 PM**
VIII.	**New Business**	**7:25 PM**
IX.	**Adjourn**	**7:30 PM**

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Upcoming meetings:

Day	Date	Type of meeting	Location	Time
Wed	1/3	Housing Committee	25 Van Ness, Room 330	3:00 – 5:00 PM
Wed	1/3	PWA Caucus	25 Van Ness, Room 330	5:30 – 7:30 PM
Mon	1/8	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Mon	1/8	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	1/22	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM
Wed	1/31	Tenderloin Community Forum	TBA	6:30 – 8:00 PM
Mon	2/5	Implementation & Evaluation Committee	25 Van Ness, Room 330	5:00 – 7:00 PM
Wed	2/7	Housing Committee	25 Van Ness, Room 330	3:00– 5:00 PM
Wed	2/7	PWA Caucus	25 Van Ness, Room 330	5:30– 7:00 PM

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2/18/00
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Minutes, Dec. 18, 2000 — HIV HEALTH SERVICES PLANNING COUNCIL

Draft until approved by Council at next meeting

DRAFT

I. Call to Order
4:40 PM

II. Roll Call
See Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
The agenda was revised, then adopted by consensus.

IV. Review and Approval of Minutes
11/27/00 Council Meeting Minutes – No changes or corrections were requested. It was moved and seconded to approve the draft of these minutes; the motion passed by a unanimous vote.

V. General Announcements
Veronika Cauley announced that she is resigning from the HIV Health Services Planning Council, while taking a moment to thank the members who have supported the inclusion of the Transgender population. (She received appreciation for three years of work and best wishes for her efforts at New College.) *Bob Teague* passed out a brochure about the National HIV/AIDS Clinicians' Consultation Center affiliated with the AETC and information about a conference on Medical Management of HIV (January 25, 2001).

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VI. Public Comment
There was no public comment at this meeting.

VII. Reports

VIII. The Mayor's AIDS Policy Coordinator
Michael Shriver reported some problems on the part of HRSA concerning the sensitivity of data from the ADAP Utilization Study. The presentation should be ready for next meeting. He said that UCSF had completed this research for HRSA on the availability of the State's ADAP and/or Medicaid programs for people of color. The study includes four states, California, New York, Florida and Texas. He wants to report the findings for California to the Council, while drawing comparisons with other states. He mentioned that patterns of healthcare access were fairly divergent from each other for African Americans and Latinos. There will be more on this interesting study at the next meeting.

IX. HIV Health Services of DPH
Laura Thomas reported that Congress had just passed its Appropriations Budget for Labor/HHS. The appropriations translate into a significant increase for the Ryan White CARE Act ($181 million increase) and for Title I (a $50.4 million increase). Other Titles, ADAP, the dental program and the Minority AIDS Initiative also got increases. In addition, there is a direct grant to San Francisco DPH within the appropriations. This will augment HIV services at SF General Hospital and the substance abuse/treatment-on-demand services (both areas receiving increases of about $1.1 million). This amount will help make up for the cuts to our EMA within the CARE Act formula funding and represents new money coming into San Francisco specifically for those two areas, both of which are important to the care system for people with HIV and AIDS. She again expressed her thanks to Congresswoman Nancy Pelosi and encouraged members to write notes of appreciation. We still don't know the amount of our Title I award for the coming fiscal year, but at least HRSA now knows its overall numbers with respect to this years federal budget and appropriations. We will probably know by the next meeting. She encouraged the Council to make plans for absorbing a

cut in funds, but does not yet have an estimate of how much the cut will be.

X. Dept. of Public Health

Jeffrey Klausner, Director of STD Prevention, presented a brief report on an outbreak of the disease, known as shigella infection. He described it as an intestinal infection that is caused by a bacterium. It can be picked up by anyone who comes in contact with infected stool. The very young, the very old, and the immune system compromised are at greater risk. It is a reportable disease in San Francisco, so all laboratories in the city report cases to the Dept. of Public Health. Many cases go unreported, however, because people with symptoms don't always get tested for this disease. Statistics show a definite increase of cases reported since June 2000, the first time since the beginning of 1996 that an increase has been noted. The summer months all showed similar increased numbers with the peak being in September 2000. The predominant number of cases is among men and is in the group of men 25 to 44 years old. This indicates that the problem didn't arise from a food-born outbreak, but rather from a sexually transmitted outbreak. As far as the reporting of sexual practices, the increased cases appear to be among men who have sex with other men, including about 20% being men who are HIV+. Obviously, the major risk factor would be oral-anal contact. He passed around copies of a flyer developed by the Dept. of Public Health to answer questions about shigella and how people can take steps that reduce risk of transmission. The message of the flyer is very direct and uses everyday language. These flyers are available for community distribution from DPH. He was asked about the recommended treatment, and he responded that a cycle of certain antibiotics is best. A danger is that untreated people may have their symptoms subside, not knowing they are infectious. He said that several people had been hospitalized as a result of this outbreak. He was asked about any corollary increase in cases of Crypto, but said this had not been seen so far.

XI. Membership Committee

Ken Pearce said that the committee had decided to bring a larger group of nominees to a vote at the next meeting of the Council in January. The committee met with three prospective nominees at their last meeting. *Laura Carcagno Guzman* said that with the resignations of Jorge Ortiz and now Veronika Cauley the Council's membership was down to 32. There are other members who have not been in compliance with the attendance requirements of five meetings per quarter. The committee may be contacting some of them in order to discuss the time commitment, and there may be other people who choose to resign. *BT* talked about the plans for a new member orientation to be held on Saturday, January 20, 2001 from 9 am to 12:00 noon. Anyone may attend and everyone is welcome. The committee is actively pursuing prospective new members. Perhaps the best way to recruit new people is through the efforts of current members. *LCG* mentioned the level of 33% membership now required to be people who are consumers of services, without affiliation to any agency. An agency affiliation means anyone who is receiving staff/consultant compensation or serving on a Board of Directors for an agency that is a recipient of Ryan White CARE Act funding. This does not include boards that are purely advisory.

XII. PWA Caucus

Gary Harrell said that the committee was putting together a comprehensive list of services, both those that are CARE funded and those that aren't. The committee is also inviting people who work as Peer Advocates, Treatment Advocates, Client Advocates and Case Managers to attend upcoming meetings of the Caucus in order to foster greater dialogue about the everyday problems facing people on the frontlines of the epidemic. The date of the Tenderloin Community Forum has been firmly established as January 31, 2001. It will be held at 201 Turk Street in the multi-use room starting at 6:30 PM. The forum will be held in collaboration with the Tenderloin AIDS Resource Center and other agencies located in he Tenderloin area. He called for each of the Council's standing committees to appoint a committee member to be a spokesperson at the forum and to explain the work and priorities of that group in about five minutes of prepared comments. Among

the other topics that he thinks will be discussed are the changes in emergency and transitional housing services as well as the issues of why some people know they are HIV+ but do not seek care. *Brad Hume* cautioned that the housing discussion needed to be focused on what is happening with emergency vouchers and with the new transitional housing. *LCG* asked that every member of the Council try to attend this forum because it is one of the ways we as Council members find out what is being experienced on the other end by those who are receiving services. *GH* said that he would like to know by the time of our next Council meeting who would be speaking from each committee. This is part of an effort to attain some measure of control over how the discussion flows in order to make the most of this interaction between consumers and the Council. *BH* said he wanted the Council to be in position to explain very clearly what our work is about and why we do what we do. The outreach efforts to bring high attendance are much more extensive than for some of the events held this past year. So, a good turn out of clients from the Tenderloin neighborhood is expected.

XIII. Housing Committee

Hazel Betsey said there was no new information at this time.

XIV. Implementation & Evaluation Committee

LCG asked members to look over the motion being put forward by the I&E Committee concerning the Hold Harmless Provision. The discussion began on the topic of conflict of interest. Marcy Fraser of Continuum and a former member of the Planning Council, was asked to read the contents of a grievance she has filed about the hold-harmless discussion that took place in the December 4th meeting of the I&E Committee. After reading this grievance, it was decided that it would have to be handled according to the Bylaws of the Council. That meant that the contents of the grievance would be discussed during the next meeting of the I&E Committee on January 8, 2001. *Stephan Oxendine* put forward his views concerning conflict of interest and voting procedures, as one of the participants at the December 4th meeting. He agreed with contentions made in the grievance with regard to some points, but disagreed with others. Marcy Fraser agreed that some of the points in her grievance would need to be corrected due to errors of fact. *SO, Jeff Byers* and other members present at the December 4th meeting concurred that conflict of interest was a real issue, especially at the particular meeting in question. Therefore, this grievance would have to be discussed in detail within the rules established in the Council's Bylaws. *LCG* mentioned that conflict of interest rules are a responsibility that all members must confront in the context of any votes on the Council or in its committees. Everyone, however, is free to fully participate in discussion concerning any and all topics as long as the conflict of interest is disclosed. *Gene Gowdey*, at this point, tried to withdraw the motion that had been brought before the Council from the I&E Committee, saying that he didn't want doubts about conflict of interest to be involved with discussion of a hold-harmless provision and a vote on that topic. *Cecilia Chung* inquired as to the rules about voting if a small number of members are present in a committee meeting and some of them must abstain due to a conflict of interest, how can votes be taken under those circumstances? The answer is that votes cannot be taken if, for example, there is only one member left who is eligible to vote. Additional members would have to take part if the vote was to be considered valid. This is one of the reasons that substantial attendance is such a high priority for membership on the Council. *Mark Dunlop* said that he felt members understood what a conflict of interest is, based upon the meeting report, showing that two members abstained from the vote on which they had declared a conflict. Those two members as well as other members present apparently reasoned that they did not have a conflict of interest with regard to the other votes taken. His analysis of the voting was that the results were not changed due to contentions about irregularities. *SO* felt that voting results were not the issue, but rather who is permitted to take part in voting. *Michelle Long Dixon* said that the Council's Bylaws are very clear that this issue regarding committee votes and their relation to conflict of interest rules must now be taken up and discussed in the I&E Committee. This is the only option for how to determine whether or not there is any substance to a grievance that has been duly filed.

This matter cannot be resolved at this Council meeting. All discussion should be referred to the appropriate committee. *Susan Shea* said that it was necessary to have a good dialogue on this issue within the committee. *JB* reminded members that their participation in the Council is governed by rules established in state laws, plus the Bylaws of the Council. A grievance can be taken all the way to the California Fair Political Practices Commission if we cannot resolve it internally. This issue of conflict of interest is a self-monitoring process. All members should take responsibility for understanding the concepts and appropriate actions that are involved.

XV. Break

XVI. Hold Harmless Provision (continued)

Michelle Long Dixon said that even though the Council was going to re-visit the process of how we held the discussion of this issue, she wanted to clarify what "hold harmless" means in this context. She emphasized the principle that any service to be held harmless should be essential to health AND essential for survival of severe need populations. Then she talked about how some of the rationale for taking this step is that it can help speed up the negotiating and contracts process, which is slow in many cases. Hold harmless applies to any across-the-board reductions in any given category or sub-category, but there may be other reasons particular to a contract, program or exhibit that could result in a cut. In that type of reduction, done as part of the monitoring process because performance standards were not being met, the Council would be asked again what to do with the resulting savings.

Jim Mitulski asked for additional comments about the earlier points on conflict of interest. *Gene London* asked that the effort being undertaken with regard to training of new and more experienced members of the Council include training on this issue of conflict of interest. *LCG* said this would happen in the fairly near future, but in the meantime she recommended that everyone read his or her copy of the Bylaws. Much about how it is defined is spelled out very clearly, especially with respect to monetary interests. There are still situations that create doubt for many members, however. So, training and practical exercises would be very helpful, particularly in connection with the process we call Prioritization. *SO* asked the Mayor's AIDS Policy Advisor to give his assistance on the definition of conflict of interest. He also said he would support an amendment to the Bylaws that would make even clearer the language that defines conflict of interest. *JB* said that wanted to encourage fuller participation from Council members who are HIV+ consumers of service and others who have a health interest in the system rather than any monetary stake.

XVII. New Business

Michael Shriver said that there had been some inaccuracy in press reports about the upcoming "consensus conference." The conference is by invitation only because the Mayor, after conferring with the AAAVL-Activists Allied Against Violence & Lies, determined that many researchers and community based organizers would otherwise not attend due to fears about safety and security. They feel threatened due to past actions taken by those affiliated with "ACT-UP San Francisco." A public venue was ruled out. Some specific people will not be invited and not allowed entrance. Other people will be invited to the January 19th meeting, including people from the Council. Obviously, the findings will be of interest to the Council's planning and evaluation activities. He also announced that the disease of Hepatitis C now has its own strategic advisory committee. Thirty thousand San Franciscans are now living and struggling with this particular disease. More attention needs to be paid to the healthcare needs of that population, including the services provided at SF General. He also announced that funding for HIV prevention services had arrived as the result of negotiations with Dupont Pharmaceuticals. It amounts to $200,000 per year for five years. A process has gotten underway within the HIV Prevention Planning Council.

XVIII. Adjournment

HIV Health Services Planning Council

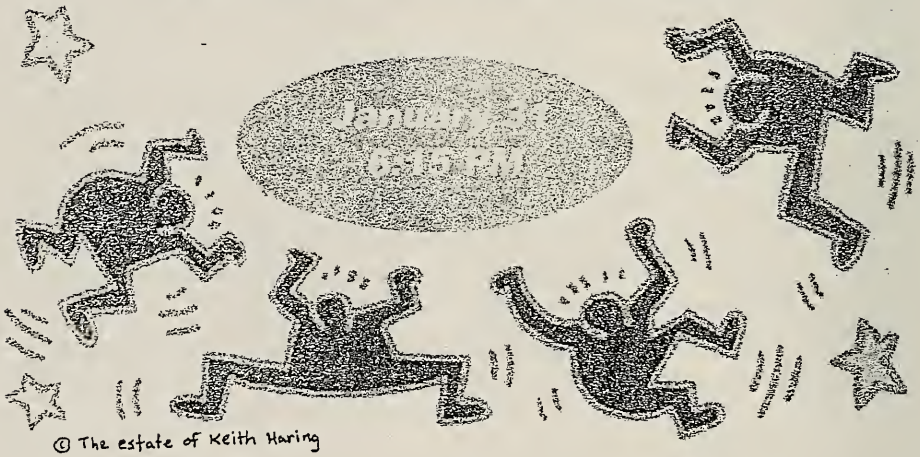
Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-10]: **Y**=Yes; **N**=No; **B**=Abstain

December 18, 2000		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]
1. Margot Antonetty	*MA*										
2. Hazel Betsey	*HB*	P									
3. Jeff Byers	*JB*	P									
4. Bart Casimir	*BC*										
5. Veronika Cauley	*VC*	P									
6. Raymond Combs	*RC*	P									
7. John Conley	*JC*	P									
8. Cecilia Chung	*CC*	P									
9. Mark Dunlop	*MD*	P									
10. Gregory Edwards	*GE*										
11. Catherine Geanuracos	*CG*	P									
12. Fernando Gomez-Benitez	*FGB*	P									
13. Gene Gowdey	*GG*	P									
14. Laura Carcagno Guzmán	*LCG*	P									
15. Gary Harrell	*GH*	P									
16. Brad Hume	*BH*	P									
17. Sam Kaplan	*SK*	P									
18. Jeffrey Klausner	*JK*	P									
19. Gene London	*GL*	P									
20. Carmen Madríz	*CM*	P									
21. Michael Meehan	*MM*	P									
22. Allen Meyer	*AM*										
23. Jim Mitulski	*JM*	P									
24. Gregory Neumark	*GN*										
25. Stephan Oxendine	*SO*	P									
26. Ken Pearce	*KP*	P									
27. Alissa Riker	*AR*										
28. Susan Shea	*SS*	P									
29. Janis Takamoto	*JT*	P									
30. Bob Teague	*BT*	P									
31. Kelly Wallace	*KW*										
32. Robert Whitford	*RW*										
33. Mary Jane Wood	*MJW*										

Tenderloin Community Forum

for people living with HIV

We want to hear from You



This Forum is sponsored by the San Francisco HIV Health Services Planning Council and its PWA Caucus, in collaboration with the Tenderloin AIDS Resource Center and other service providers in the neighborhood.

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There will be a door prize/raffle, Pizza and refreshments will be provided, and Each participant will receive a food voucher.

▼▼▼▼▼

201 Turk Street Apartments, Multi-Use Room ■ 6:15 PM
Wednesday, January 31, 2001. Please be on time.

For further information call 563-8131

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